

**Clinical psychologists' views about talking  
to people with psychosis about sexuality and intimacy:  
A Q-methodological study**

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## Thesis Abstract

The sexual and relationship needs of people with psychosis are often overlooked by healthcare professionals. There is significant evidence that access to intimate relationships provides long-term psychosocial benefit, and people with psychosis have indicated their desire to talk to clinicians about sexuality. Clinical psychologists are involved in the provision of therapeutic interventions for people with psychosis, and are well-placed to explore these complex needs.

Following a recent increase in research exploring service-user experiences of sexuality and intimacy, chapter one reviewed qualitative literature relating to psychological and social barriers to the development and maintenance of sexual and intimate relationships. Nine studies were included in the review, and critical appraisal and thematic synthesis of findings was conducted. Methodological quality of papers was mixed, although many papers lacked coherent descriptions of methodologies. Key findings included evidence that psychosis contributes to a diminished sense of sexual self; side-effects of anti-psychotic medication have distressing psychological and emotional consequences; and intimacy is the most important aspect of close relationships for people with psychosis. Chapter two explored the subjective views of clinical psychologists about discussing these complex sexual and relationship needs using Q-methodology. Participants ranked 66 statements relating to psychosis, sexuality and intimacy. Three shared perspectives were identified, including one perspective that revealed many clinical psychologists that were comfortable in talking about sexuality and intimacy. One perspective highlighted risk and appropriateness as being the more important clinical aspect in terms of addressing sex and intimacy. A final perspective that demonstrated that a minority of clinical psychologists do not feel competent or sufficiently trained to assess sexuality and intimacy. The practical implications are discussed in terms of recovery models and training needs. Finally, chapter three provides an account of the author's experience of preparing the research and completing the thesis. The reflective account bases each aspect of personal and professional learning on a recovery principle.

Total word count: 19, 539 (excluding references and appendices)

## Preface

The literature review presented in the first chapter and the empirical study in the second chapter have been written for submission to the academic journal *Clinical Psychology and Psychotherapy*. The journal was chosen for its high impact factor and target demographic that includes mental health professionals as well as clinical psychologists.

The journal has previously published numerous articles on psychosis and sexuality as well as studies using Q-methodology. Although the current journal guidelines do not specify word limits for review papers or original articles (Appendix Q), the expected word limits were stated as being acceptable by one of the journal editors in personal communication (Appendix R). The thesis has been formatted in concordance with Staffordshire University thesis submission guidelines.



## **Chapter 1: Literature Review**

### **Barriers to Accessing Sexual and Intimate Relationships for People with Psychosis: A Literature Review and Thematic Synthesis**

**Word count: 8, 534**

## **Abstract**

Sexuality and intimate relationships are crucial to individual wellbeing, yet individuals experiencing mental health difficulties struggle to access social and relationship opportunities. Despite recent efforts to improve access to sexual health services in the United Kingdom, people with mental health difficulties report the lowest sexual satisfaction in population studies. For people with psychosis, concepts of sexual relationships are dominated by research that focuses on physiological side-effects of antipsychotic medication or perceptions that sufferers engage in deviant sexual practices. There is a paucity of research exploring the psychological and social barriers that prevent people with psychosis from developing intimate relationships from a lived experience perspective. This qualitative literature review and thematic synthesis includes nine articles and identifies five overarching factors that limit prospects for people with psychosis, including psychological and social barriers, lack of external support, concerns about the content of relationships, personal barriers and systemic barriers. A major barrier is the indirect traumatising and distressing psychological consequences caused by side-effects of antipsychotic medication that are frequently overlooked by mental health professionals. Findings are conceptualised within recovery models of mental health care. Implications for clinical practice include the need for specific assessment tools and support for professionals to explore sexual and relationship needs with service-users.

## Introduction

### *Importance of sex and intimacy*

Sexuality and intimacy are core human needs, crucial to individual quality of life and fundamental in creating a sense of self and meaning (Baumeister & Leary, 1995; Lehmiller, 2014; Weeks, 2009; World Health Organisation, 2015). Intimate relationships and sexuality represent far more than simply the physical act of sex itself. A range of emotions and experiences are present including erotic desires and urges, sensuality, stimulation and pleasure, and intimacy and closeness (O'Donovan & Butler, 2010) on myriad physiological, psychological and social levels (Tierney, 2008). Absence of intimate relationships diminishes mental health and wellbeing (Chan & Yu, 2004; Hawkley & Cacioppo, 2003; Heinrich & Gullone, 2006; Trémeau, Antonius, Malaspina, Goff, & Javitt, 2016).

Population studies show that many people are unable to access sexual relationships and fulfilment despite national drives for improved sexual health outcomes. Although some areas of sexual health such as unplanned pregnancies, contraception use and sexually-transmitted diseases have improved since the national focus on improved outcomes began, sexual difficulties are commonplace (Mitchell, et al., 2015). People with physical and mental health difficulties experience poor sexual satisfaction (Field et al., 2013). There is a gap in terms of provision of integrated services for individuals with both mental health difficulties and sexual health needs (Field et al., 2016).

The British Government has highlighted the need to recognise the rights of all individuals to sexuality, relationships and sexual health (Department of Health, 2013). Policy guidelines state that positive sexual health outcomes in the UK should include access to appropriate support and information, a high standard of service provision and a focus on reducing stigma and inequalities. However, despite efforts to prioritise sexuality and intimacy, opportunities for individuals to develop and maintain relationships are limited if they are not supported by health professionals to do so (Dyer & das Nair, 2013; Quinn, Happell, & Browne, 2011b).

### *Research biases on sex and intimacy in psychosis*

The sexuality of people with psychosis has been regarded as more of a 'clinical' problem than a psychosocial challenge (Dobal & Torkelson, 2004). Assumptions that individuals with psychosis are unable to engage in normal relationships pervade the literature, driven by biased perspectives that focus on biological factors associated with sexuality, specifically medication side-effects, or stereotypes involving risky or bizarre sexual behaviours (Kelly & Conley, 2004). People with psychosis have been described as '*undersexed or oversexed*' (Gascoyne, Hughes, McCann, & Quinn, 2016) or '*asexual*' (Buckley, Robben, Friedman, & Hyde, 1999).

As sexually transmitted diseases such as HIV and AIDS became more widespread in the 1980s and 1990s, perceptions emerged that individuals with severe and enduring mental health problems would contribute to an increase in sexually transmitted diseases (Gray, Brewin, Noak, Wyke-Joseph, & Sonik, 2002) and unwanted pregnancies (Miller, 1997). These assumptions are only partly correct. In fact, although rates of sexually-transmitted diseases tend to be higher in individuals with mental health problems than for the general population, the risk of contracting HIV/AIDS is lower for severe mental health problems than for low mood and other psychological difficulties (Robson & Gray, 2007). In terms of pregnancies, however, women with psychosis are at higher risk of unwanted pregnancy than those without mental health difficulties, however this is often in the context of issues such as sexual assault or absence of contraception (Coverdale, Turbot, & Roberts, 1997; Kelly & Conley, 2004).

Numerous studies have explored the impact of antipsychotic medication on sexual drives and physiological functions, but they are medically-orientated and driven by quantitative methodologies; a comprehensive review from 2007 included over 30 such studies published between 1976 and 2006 (Murthy & Wylie, 2007), and a recent review included 8 large-scale studies conducted between 2004 and 2007 alone (Park, Kim, & Lee, 2012). Antipsychotic medication causes well-documented extrapyramidal side-effects, including ejaculation difficulties, reduced libido and weight gain that can impair individuals' quality of life and significantly affect sexual satisfaction (Baggaley, 2008). Studies have recently shown that sexual difficulties

are present in people with early-onset psychosis prior to taking antipsychotic medication, however (Marques, et al., 2012). Whilst medication clearly impacts on sexual functioning (Schmidt et al., 2012), some aspects result from the symptoms of psychosis and psychological factors that require further research (de Boer, Castelein, Wiersma, Schoevers, & Knegtering, 2015). Most clinicians avoid assessing sexual side-effects with clients (Gascoyne et al., 2016), such that people with psychosis are reluctant to open conversations themselves. No qualitative studies to date have explored the psychological burden of antipsychotic sexual side-effects.

### *The role of relationships in recovery*

The sexual and relationship needs of service users are overlooked in mental health services (McCann, 2010b). The long-term social consequences of psychosis include impaired social skills which impede the development of long-lasting relationships (Pillay, Lecomte & Abdel-Baki, 2016). Stigma, prejudice, and a perception that people with psychosis should not be engaged in sexual relationship often mean that their relationship needs are marginalised (McCann, 2003). People suffering with psychosis are often survivors of sexual abuse or traumatic events (Read, Agar, Argyle, & Aderhold, 2003; Kelleher et al, 2013), and the emotional consequences of these experiences can be a major barrier to accessing support around sexual relationships. Low self-confidence and self-esteem and a decline in self-care often reduce the likelihood that people access support (McCann, 2010b).

Although the processes involved in recovery from psychosis are subjective and differ according to the individual (Williams, Leamy, Bird, Harding, Larsen, et al., 2012), some common aspects of the recovery journey have contributed to a widely-accepted definition amongst service-users (Slade, Adams, & Hagan, 2012). Recovery now tends to be conceptualised as a model that involves principles such as redefining one's identity, social connectedness and a sense of empowerment (Leamy, Bird, Le Boutillier, Williams, & Slade, 2011). Health services, professional bodies and advocacy groups have highlighted the role of social support in recovery from psychosis (British Psychological Society, 2014; The Schizophrenia

Commission, 2012). Individual recovery principles such as social support networks, close personal relationships, finding meaning and being able to regain one's independence sit alongside traditional treatments such as antipsychotic medication and psychological interventions in terms of importance (Tew et al., 2012). Early Intervention services aim to support clients to develop the knowledge and skills to access social networks (McGorry, Killackey, & Yung, 2008), and NICE Clinical guidelines recommend social skills programmes to augment traditional treatment approaches (National Institute for Health and Care Excellence [NICE], 2014). Interventions designed to support people with psychosis in developing social skills yield positive outcomes in terms of reduced relapse and rehospitalisation, and improved quality of life (Almerie et al., 2015; Alvarez-Jiminez et al., 2013).

People with psychosis have the same basic human needs as the rest of the population, yet it is often the everyday aspects of life that can be easily taken for granted that are fundamental to the recovery pathway for sufferers. Overlooked psychosocial freedoms such as independent living, social contact and being in a relationship generally predict greater recovery from psychosis (Albert et al., 2011; Onken, Craig, Ridgway, Ralph, & Cook, 2007). Finding one's purpose in life, developing a sense of autonomy and identity, and feeling a sense of security and connectedness in one's personal relationships are all established predictors of positive outcomes in the recovery pathway (British Psychological Society, 2014; Drake & Whitley, 2014; Tew et al., 2012). However, quite how important relationships are to recovery may be underestimated. Close relationships and a sense of belonging within relationships appears to be one of the core aspects of recovery, in terms of people feeling supported, understood and listened to (Soundy et al., 2015). Although evidence suggests that relationships can facilitate long-term recovery (Albert et al., 2011; Lee et al., 2013), people with psychosis have limited opportunities to develop social networks and struggle to access support in developing intimate or romantic relationships (Gayer-Anderson & Morgan, 2013; Hensel, Banayan, Cheng, Langley, & Dewa, 2016).

## *Supporting people with psychosis to access intimate relationships*

Nursing researchers have recently begun to explore service-user perspectives on accessing sexual relationships (e.g. McCann, 2010b) and nurses' attitudes and challenges to discussing issues of sexuality with clients (Quinn, Happell, & Browne, 2011a; 2011b; Wright & Pugnaire-Gros, 2010). People with psychosis have highlighted sex and intimacy as a key area of need, with some studies suggesting that intimate relationships are rated as almost as important as physical health and housing (Fleury, Grenier, Bamvita, & Tremblay, 2012). The sexual expression and intimate relationship needs of people with psychosis are highlighted as an area of concern by their families (Iyer, Loohuis, Pawliuk, Joober, & Malla, 2011) and healthcare staff (Hensel et al., 2016). Most importantly, service-users have expressed their desire to discuss sex and intimacy, and look to mental health professionals to initiate conversations (McCann, 2000).

Clinical psychologists have highlighted the need for greater focus on research into the support that can be offered to people with psychosis and on interventions designed to support them in accessing relationships. A recent review of socially-orientated interventions demonstrated the capacity for incorporating aspects of clients' social networks in the treatment process, including practical components to promote social inclusion and networking (Harrop, Ellet, Brand, & Lobban, 2015). They highlight the need for further action on the part of clinicians to develop therapeutic techniques to assist with dating skills. To date, little research has explored how mental health professionals attend to the intimacy needs of those with psychosis.

The shift towards recovery-focused and client-centred perspectives has generated important research that incorporates the views of people with psychosis on their experiences of intimate relationships, as well as on interventions that support people to overcome relationship barriers. However, for interventions to be effective and evidence-based, a sound understanding of the social and psychological barriers to accessing and maintaining relationships is required.

### *Aims of the review*

Research on sexuality and intimacy in psychosis has been dominated by quantitative studies exploring the sexual dysfunction and antipsychotic side-effects and many reviews have synthesised this literature (e.g. Chiesa, Leucci, Serretti, & De Ronchi, 2013; Schmidt et al., 2012). There has been an upsurge in qualitative literature in the last two decades that has explored service-user perspectives, yet no review to date has focused on phenomenological aspects of sexual expression and intimate relationships for people with psychosis. This review aims to develop an understanding of the psychological and social barriers to developing and maintaining sexual and intimate relationships for people with psychosis exploring the qualitative literature.



## Method

### *Stage 1: Systematic search*

#### Eligibility criteria:

The literature search was guided by the SPIDER search tool (Cooke, Smith, & Booth, 2012), a search strategy developed for use in the synthesis of qualitative research:

**Sample:** Individuals experiencing psychosis, including those with a diagnosis within the schizophrenia spectrum of disorders including schizophrenia or schizoaffective disorder. Studies were still included if samples included individuals with other diagnoses in addition to psychosis e.g. major depression, bipolar disorder.

**Phenomenon of Interest:** The experience of social and psychological barriers to accessing or maintaining intimate or sexual relationships for individuals with psychosis.

**Design:** Qualitative design including interpretative phenomenological analysis (IPA), grounded theory, thematic analysis, narrative analysis. Quantitative studies, case studies or reviews or that focused on other mental or physical conditions were excluded.

**Evaluation:** Interviews or focus groups exploring the experiences of service-users, and were published in the English language.

**Research Type:** To ensure that articles focused on the experience of service-users, and not an existing medical or psychiatric phenomenon, only qualitative studies were included.

Articles contributing to the review were identified in two stages. A systematic search of major databases was conducted using AMED, MEDLINE, PsycINFO, SPORTDiscus, AgeLine, CINAHL Plus, PsycARTICLES and Web of Science databases. Search terms included 'psychosis OR schizophrenia' and 'sexuality' OR 'intimacy' OR 'intimate relationships' OR 'close relationships' OR 'romantic relationships'. The search was limited to include articles from 1999 – onwards to ensure inclusion of service-user focused research. A search of grey literature was also conducted to identify relevant articles, and reference lists of articles and the publications of key authors were searched. A Google Scholar search using the

original database search terms was also conducted, and the first 100 results were checked. The search process is shown in Figure 1.1.

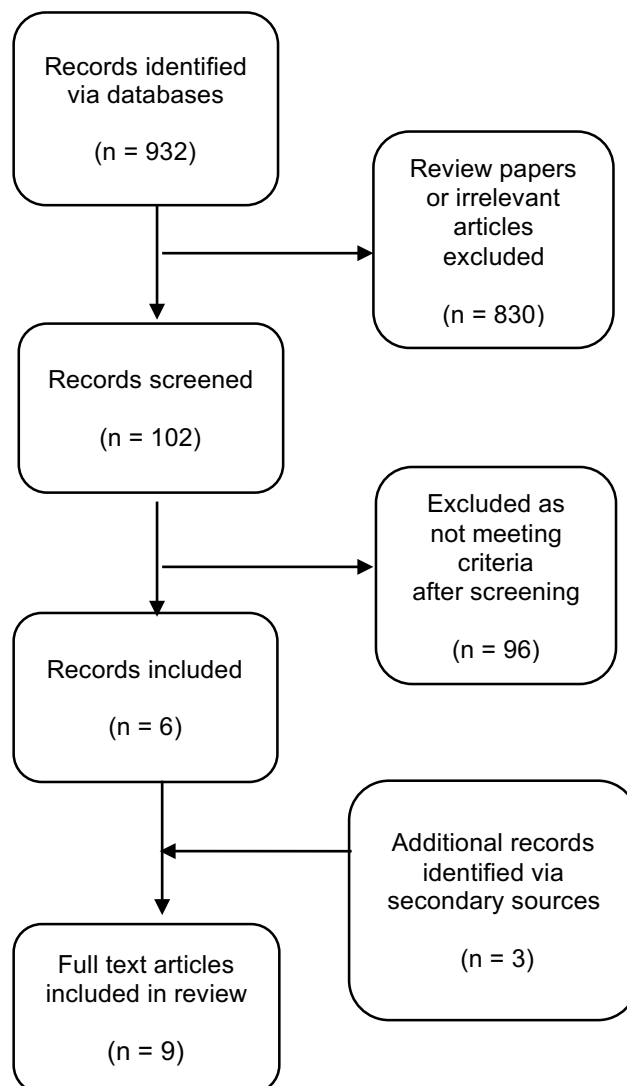


Figure 1.1. Article search flow chart.

### *Stage 2: Critical appraisal*

A detailed quality assessment process was applied to each article based on the framework published by the National Centre for Social Research (Spencer, Ritchie, Lewis, & Dillon, 2003). The appraisal tool comprises 18 questions designed to determine methodological quality in qualitative research, including the underlying philosophical assumptions of the qualitative approach, study design, participant

sample, data collection and the reporting of themes. The tool easily allows researchers to appraise different methodological processes of the research, and it can also be used to generate a summary score of methodological quality for each article.

A scoring system was developed to determine an overall quality score for each article adapted from a previous review (Dyer & das Nair, 2013). A score of 1 - 4 was allocated for each of the 18 methodological process questions: a score of 4 indicated absence of issues (e.g. the description of a process was well-documented with no or brief omissions); 3 indicated minor issues (e.g. the process was well-documented with only small details); 2 indicated major issues (e.g. the process contained major omissions); 1 indicated an article that was untrustworthy (e.g. a description was absent). A total quality score of 72 was possible for each article. A quality percentage score was then computed by converting the total score to a percentage.

### *Stage 3: Thematic synthesis*

Thematic synthesis was selected as the most appropriate method for analysing the findings of included articles as this approach is an accessible and rigorous method of analysing and reducing qualitative data into coherent themes whilst maintaining the integrity of the data from which it is derived (Thomas & Harden, 2008). Thematic synthesis was conducted in three steps: i) study results were coded line by line and transferred to a database; ii) the meaning of each code was placed with a piece of descriptive data to support it; iii) the construction of themes, with detailed third-order interpretation exploring the wider context of the theme.

Although a variety of methods exist for the identification and extraction of qualitative findings for reviews, not all methodological approaches clearly define what constitutes data or findings should be included (e.g. Thomas et al., 2004). Some approaches take a broad perspective in which all text categorised as results or findings are extracted, whilst more focused approaches include only original data that addresses the research question (Noyes & Lewin, 2011). To ensure that no relevant findings were excluded, and in accordance with the methodology for

thematic synthesis (Thomas & Harden, 2008), all content labelled as results or findings was extracted.

## Results

### *Stage 1: Systematic search*

The database search retrieved 932 articles. Each article was screened by its title, and reviews or papers with titles clearly not relevant to the present review were excluded, removing 830 articles. The remaining 102 articles were checked for further relevance based on criteria that they were qualitative articles and contained discussion about psychosocial barriers to accessing intimate relationships within the results section. Articles not meeting criteria were excluded. Six articles were found via the database search, and the secondary search identified a further three articles. Nine articles were included in the final review process. General characteristics of included articles are shown in Table 1.1.

### *Stage 2: Critical appraisal*

Individual critical appraisal ratings for each article are shown in Appendix A. The highest quality rating achieved was 88%. Of the nine articles, three scored higher than 75%, three achieved scores between 60 – 70%, and two achieved scores between 50% - 60%. Only one article scored lower than 50%. Percentage scores are shown in the final column of Table 1.1.

### *Study strengths*

One study documented amendments made to the interview schedule following feedback from the pilot study (McCann, 2000). Another study (Volman & Landeen, 2007) described the process of supporting data gathered through semi-structured interviews with field notes and reflective journals.

Data analysis and thematic development methods included cross-checking findings between researchers (Hirschfeld et al., 2005) and a service-user advisory group (Östman, 2014). One study using Grounded Theory (Redmond et al., 2010) checked themes by including an iterative method of ratifying themes during data collection,

Table 1.1

Characteristics of included articles.

Study reference	Aims	Sample size (n =)	Sample composition	Location	Qualitative methodology	Key relevant findings	Overall quality score (%)
McCann (2000)	To identify sexual and relationship needs of people with psychosis being cared for in hospital and obstacles to this	11	7 male, 4 female aged 18 - 29	London, UK	Unspecified data analysis technique	Participants saw sexual relationships as being based on intimacy and not just sexual intercourse. Despite barriers to accessing relationships, participants had hopes for developing future relationships.	46
McCann and Clark (2004)	To explore how young people experience psychosis as an embodied illness and find meaning	9	5 male, 4 female	New South Wales, Australia	Descriptive phenomenology	The experience of psychosis affected participants' relationships with others. Fear of discrimination negatively affected relationships, as did fear of rejection. Side effects of medication was a barrier to sexual expression.	64
Hirschfeld, Smith, Trower & Griffin (2005)	Explore the subjective experiences of young men experiencing their first episode of psychosis	6	Males aged 19 - 29	Birmingham, UK	Grounded theory	Participants described personal difficulties in maintaining relationships in general, including trust and low self-esteem, which also acted as a barrier to intimate relationships.	88

Volman and Landeen (2007)	Develop an understanding of how people with psychosis experience and perceive their sexuality	10	5 male, 5 female	Canada	Grounded theory	Despite the barriers that psychosis created in terms of sexual experience, participants still described themselves as having sexual identities. Barriers discussed included side effects of medication and difficulties in forming relationships.	78
McCann (2010)	Exploration of the sexual and relationship experiences of individuals with psychosis living in the community	30	15 male, 15 female aged 22 - 57	London, UK	Unspecified data analysis technique	The close, intimate aspects of relationships were as important to participants as sexual acts themselves. The difficulties in maintaining relationships was addressed, including institutional barriers, lack of support from services and medication side effects.	69
Redmond, Larkin and Harrop (2010)	To explore the significance of romantic relationships in young people with psychosis	8	5 male, 3 female, aged 21 - 31	West Midlands, UK	Interpretive Phenomenological Analysis (IPA)	Although close relationships were seen as representing 'normality' and part of the recovery process, several barriers were identified including difficulties initiating relationships and perceived risks and dangers, such as to one's sense of self and sense of personal security.	86

Östman and Björkman (2013)	To explore the impact of psychosis on sexuality	18	15 male, 3 female aged 32 - 41	Sweden	Thematic analysis	Participants described fears and insecurities about relationships, including feelings of unattractiveness and the responses of significant others towards them. The side effects of medication were discussed, as was the need for greater support from health professionals.	61
Ostman (2014)	To determine how people with severe mental illness experience their sex lives and satisfaction with it	37	25 male, 12 female, aged 33 - 82; mixed diagnoses, 55% with psychosis	Malmö, Sweden	Thematic analysis	Relationships and sexuality were seen as having no place in severe mental illness, and numerous barriers were discussed including social difficulties and shyness. Lack of opportunity to develop intimate relationships was an issue, and lack of support from services was also addressed.	54
Boucher, Grouleau, & Whitley (2016)	To examine the role of sexual and intimate relationships from service-users' perspectives	35	Aged 18+ with mixed diagnosis	Montreal, Canada	Thematic analysis	Close relationships and intimacy were seen as being part of the recovery process. Barriers included the experience and symptoms of psychosis, lack of opportunities to develop relationships and practical barriers such as lack of private space.	54

*Note.* Unless specified, samples comprised participants only with psychosis.



discussion of the findings at a qualitative peer group and triangulation of the data. The descriptions of findings and any weaknesses in approaches to presenting results and conclusions in the literature was generally good, although three studies failed to exploit the quality of the data by extracting the complexities of participants' comments (McCann, 2000; 2010a; Östman, 2014) which could reduce the validity of findings.

In terms of attention to ethical issues, one study described detailed processes to ensure participants' distress was minimised (Östman, 2014); the study was conducted in partnership with a service-user led research group, participants were asked to select the location that they were interviewed, and were told they could be accompanied by a supportive healthcare worker to provide emotional support.

### *Study limitations*

Approaches to sampling and the recruitment of participants differed across studies. Three papers used sampling methods drawn from their chosen qualitative approaches (Hirschfeld, Smith, Trower, & Griffin, 2005; Redmond, Larkin, & Harrop, 2010; Volman & Landeen, 2007). The remainder of studies used self-selection strategies, with participants being recruited conveniently from health services records or from inpatient settings. Two studies failed to discuss the limitations of the participant sample or recruitment strategy (McCann & Clark, 2004; McCann, 2010a). Four studies excluded the study setting (McCann, 2000; McCann & Clark, 2004; Östman & Björkman, 2013; Volman & Landeen, 2007), limiting the generalisability of findings.

All studies used interviews but failed to discuss the limitations of this approach. No studies described the interviewer's level of expertise or experience or the efforts made to reduce potential bias on the part of the researcher. Some studies did not clearly describe or defend the qualitative approach; for example, two studies failed to clearly state any qualitative methodology (McCann, 2000; 2010), and three further studies provided only a limited description of the approach or a rationale for it (Boucher et al., 2016; Östman, 2014; Östman & Björkman, 2013).

Three studies did not describe how the validity of themes was checked or how concepts emerged from the data. Only in one study was the credibility of findings questioned (Östman & Björkman, 2013), as this study failed to include data extracts to emphasise themes nor an adequate evaluation of how themes were developed.

All studies documented ethical processes, but only three studies described detailed measures to minimise participant distress (Hirschfeld et al., 2005; McCann, 2010a; Redmond et al., 2010). Evidence of reflexivity was absent in most of the studies, with only a few studies commenting on the philosophical position of the researchers or how their role may have affected the study (Hirschfeld et al., 2005; Redmond et al., 2010; Östman, 2014).

### *Stage 3: Thematic synthesis*

Thematic synthesis revealed five broad themes with subthemes: social and psychological barriers to accessing relationships, gaps in external support, concerns about the content of relationships, personal and individual barriers, and institutional and healthcare barriers. An example of the thematic synthesis process is shown in Appendix B.

#### *Social and psychological barriers to accessing relationships*

This theme described the emotional, psychological and social barriers to accessing relationships as a consequence of living with psychosis.

#### *Impact of psychosis emotionally and psychologically*

The emotional effects of psychosis impacted indirectly on people's ability to approach members of the opposite sex; young men said social anxiety added to feelings of isolation as they felt unable to approach women they were attracted to, despite desires to (Hirschfeld et al., 2005). Others described feeling shy and uncertain about their social skills when prospective partners were present (Östman, 2014), and the shame associated with other people knowing that they had been

unwell (McCann, 2010a). Lack of confidence and low self-esteem prevented people approaching someone that they were attracted to (McCann, 2010a; Östman, 2014; Redmond et al., 2010).

### *Relationships incompatible with psychosis*

People described the impact of living with psychosis and the losses they had experienced as a result. The loss of friendships was normal for people with psychosis (Hirschfeld et al., 2005), as friends retreated or avoided them (McCann & Clark, 2004). When relationships had ended badly, people spoke of feeling traumatised and losing confidence (Redmond et al., 2010). One study described psychosis and romantic relationships as 'incompatible' (Redmond et al., 2010).

Psychotic experiences negatively affected relationships, as delusional beliefs prevented people from being able to trust people or to feel confident in their own minds (McCann & Clark, 2004). Distressing voices and hallucinations meant that they could not distinguish between psychotic content and their partners' words, as expressions of love and devotion were often challenged or contradicted by voices (Volman & Landeen, 2007). In some cases, voices and delusions caused people to believe that their partner was an imposter (Boucher et al., 2016). Psychosis often led people to feel that something might go wrong in their relationships because of the illness, and this caused reluctance to expose partners to the negative aspects of their experiences (Östman, 2014). Willingness to reveal oneself and allow oneself to be vulnerable depended on the quality of the relationship and sense of security (McCann & Clark, 2004).

### *Psychosis affects sexual identity*

Psychosis contributed to diminished sexual identity (Volman & Landeen, 2007). People described how opportunities to enjoy sexual and intimate relationships receded with the onset of psychosis (McCann, 2010a), and that opportunities for genuine closeness in a relationship where people felt real love and affection had to be surrendered. It was not abnormal for people to say that their sexual relationships

had been healthier before the onset of psychosis (Östman & Bjorkman, 2013), and some said that they had not had sexual contact for twenty years (Östman, 2014).

#### *Lack of external support to access relationships*

A theme emerged relating to gaps in support mechanisms to enable people with psychosis to access relationships, in terms of attitudes, skills and resources.

#### *Lack of skills and resources to develop relationships*

Aspects of people's lives that facilitated development and maintenance of relationships were missing, including opportunities to learn social skills before the onset of psychosis (McCann, 2010a; Östman, 2014). Some respondents said that the pressure of being a 'salesman' or 'cold calling' when approaching people exposed their lack of interpersonal skills and meant that they struggled to 'read signals' from the opposite sex (Volman & Landeen, 2007). People subsequently avoided social gatherings (McCann & Clark, 2004). A lack of existing social networks was also an issue (Boucher et al., 2016) as there was a sense that it was easier to meet potential partners through friends (Redmond et al., 2010).

A lack of practical resources also impacted on relationships. Lack of employment was a barrier as it meant that the opportunities to meet new people and forge new social networks were fewer. Concurrently, the financial implication of not having a job meant that people had no money, which resulted in them feeling that they would not be able to take a potential partner out on dates (Boucher et al., 2016). For some who were already in a relationship, lack of financial stability was distressing and meant that plans to have a family and provide a sense of security to a partner and a baby were not achievable (McCann, 2010a). Living in an isolated, rural community left people bored, feeling trapped and unable to make plans (McCann & Clark, 2004).

### *Lack of support from family members and friends*

Parents were described as well-meaning, but good intentions could be an obstacle; family members would not be supportive in people's pursuit of developing relationships, or would actively discourage them from pursuing a relationship if a partner was deemed unsuitable (Redmond et al., 2010). Families were only supportive if the person suffering with psychosis was interested in marriage (McCann, 2010a). People said that although friends may not be able to offer solutions to relationship issues (Östman, 2014), they were available to discuss relationship issues with in the absence of support from health professionals (Östman & Bjorkman, 2013; Volman & Landeen, 2007).

### *Stigma and rejection*

People described how members of the public could be cruel in their interactions with them (Östman & Bjorkman, 2013). Some people had experienced rejection from prospective partners who had found out that they had a mental illness (Boucher et al., 2016; Redmond et al., 2010; Volman & Landeen, 2007). Others lived in fear of 'ridicule and rejection' (McCann & Clark, 2004), and were reluctant to let their partners, partner's family and friends know that they had been unwell because they anticipated responses of shock or fear (Redmond et al., 2010). The consequences of such social stigmatisation were that people concealed their psychological difficulties or told people that they were suffering from less severe mental health problems such as depression because of the fear of being judged. This resulted in people becoming resigned to a life without sexuality and intimacy, adding to feelings of despair, hopelessness and inertia (McCann & Clark, 2004).

### *Concerns about the content of relationships*

This theme revealed the important components of relationships, in terms of people's needs and desires as well as previous experiences and negative expectations of relationships.

### *Need for intimacy and support greater than for sexual activity*

Closeness in an intimate relationship was more important than sexual activity (McCann, 2000; 2010a; Östman & Bjorkmann, 2013) and intimacy involved more than the physical act of sexual intercourse (McCann, 2000). Sexuality was secondary to the intimacy associated with a relationship in which partners were emotionally close (Volman & Landeen, 2007), and the quality of the relationship outweighed sexuality (Östman & Bjorkman, 2013). In the context of coping with the social isolation associated with psychosis, a relationship based on closeness and intimacy provided a buffer against loneliness (Volman & Landeen, 2007).

Important elements of intimate relationships comprised physical and emotional aspects that made people feel cared for, supported and understood. These included trust, honesty and straightforwardness (Östman, 2014) and companionship and affection (Volman & Landeen). Having a partner that was kind, supportive and loving was important (McCann, 2010a). Having a partner that was both a friend and a lover was considered more desirable (Redmond et al., 2010). Sexual contact was important in the context of intimacy, closeness and love-making – cuddling and kissing (McCann, 2000), foreplay, oral sex and ‘messaging about’ (McCann 2010a).

### *Need for terms of relationship to be appropriate*

Clear conceptions emerged relating to how people with psychosis view intimate relationships and what important aspects within relationships were. It was important that people knew someone well before embarking on a relationship with them, and that potential partners made people feel secure in the relationship (Redmond et al., 2010). People wanted acceptance of themselves as a person, including their psychological difficulties (McCann, 2010a). It was important that potential partners had experienced some difficulties of their own to provide some balance to the relationship, in terms of the amount of the adversity both partners had experienced, to indicate that a romantic partner might be able to empathise with a partner with mental health difficulties. Partners being understanding was a key element of what people hoped for in a relationship (Östman & Bjorkman, 2013; Redmond et al., 2010). People also hoped to develop relationships with partners with whom they

could have a meaningful future, which involved marriage and starting a family (McCann 2010a).

### *Fears and expectations about relationships*

People felt resigned to taking opportunities that were available to them in the absence of being able to achieve what they genuinely desired from a relationship. This resulted in a trade-off in terms of having either sexual activity or intimacy, in that relationships contained either one or the other of these desired aspects of relationships but not both. Partners did not try to understand the difficulties associated with sexual contact for people with psychosis, or failed to make the effort to create feelings of intimacy. Settling for a lack of safety in a relationship where a partner was violent was also an issue (McCann, 2010a). People also mentioned fears that they would lose their individuality and sense of self in a relationship, trying to be what they believed their partner wanted and fitting in with these expectations of them rather than being themselves (Redmond et al., 2010).

Women were concerned that they were vulnerable to being used by attractive male partners who knew that they experienced psychological difficulties (Redmond et al., 2010). Men could use women for sex and then reject them, as their privileged position meant that they could take advantage of them (McCann, 2010a).

Relationships with other service-users were unappealing because of potential risks or challenges. People were worried because coping with psychosis was challenging enough without having to support a partner managing similar difficulties which might impede their own recovery (McCann 2010a). Others had already had a relationship with a service-user and had found it emotionally challenging (Redmond et al., 2010). People seemed resigned to the prospect of having to settle for the relationship opportunities available to them because of the existing barriers in finding the partner that they hoped for (Boucher et al., 2016).

### *Personal barriers to accessing relationships*

This theme described both the direct and indirect effects of psychosis on relationships. Indirect effects included the implications of psychotic experiences and the effects on sexual self, whilst indirect consequences included the emotional and psychological aftermath of psychosis and the barriers this posed to sexuality and intimacy.

### *Difficulties talking about sexual and relationship issues*

There was some anxiety and initial trepidation about talking about sexuality and intimacy, but once the conversation began people felt comfortable (McCann, 2010a). Reluctance appeared to be related to the emotional consequences of opening a conversation about sexuality or intimacy, as people might feel vulnerable, embarrassed or ashamed (Volman & Landeen, 2007). Others said that having a conversation depended on which mental health professional they were talking to (McCann, 2010a), and that they would only speak to clinicians if the quality of the relationship enabled such a conversation (McCann, 2000).

### *Impact of alternatives to intimate relationships*

Substitutes for genuine sexual relationships were associated with an emotional cost. Whilst masturbation provided a form of alternative sexual expression however, it was associated with guilt, shame and less sexual satisfaction (Östman & Bjorkman, 2013; Volman & Landeen, 2007). Excessive masturbation whilst in hospital also resulted in genital pain which impacted on sexual ability when with a partner (McCann 2010). People also spoke of the shame associated with accessing prostitutes for sexual satisfaction (McCann, 2010a; Östman & Bjorkman, 2013).

### *Personal experiences impacting on ability to enjoy relationships*

People's experiences of loss and trauma had significant psychological consequences. Historical sexual abuse was mentioned only once (Östman &



Bjorkman, 2013); the respondent in this case said her experiences resulted in her feeling 'dirty, or inappropriate', reducing her ability to enjoy sexual activity. Other traumatic experiences were described; in one study, the death of two children left one respondent feeling hopeless about her future relationships (McCann, 2010a). Some participants perceived that being homosexual and experiencing psychosis was perceived as being a dual barrier to accessing relationships (Östman, 2014).

### *Systemic and institutional barriers to accessing relationships*

This theme highlighted the barriers to accessing relationships people with psychosis experienced from the different systems and networks they interacted with. These issues were directly linked to the responses of or lack of action on the part of mental health services and staff.

#### *Lack of support from healthcare staff and institutions*

People are unaware of their sexual rights in psychiatric institutions and mental health professionals' role in supporting sexual health (McCann, 2000). Whilst psychiatrists offered some support, this was not specifically for sexual or relationship issues (Östman, 2014). Psychiatrists sometimes ignored people's complaints (Östman & Bjorkman, 2013), meaning people were reluctant to ask questions as they perceived that there was a risk they were challenging the structural hierarchy within the institution (McCann, 2000). However, it was important to take risks and attempt to talk about sex and intimacy with clinicians, because when people were listened to they felt understood and empowered (Volman & Landeen, 2007). There was a risk that making references to sexual activity or desire could be taken as an indication of acute mental illness and dealt with as such by staff by moving people to more secure settings. People also felt that health professionals viewed relationships amongst people with psychosis as 'weird' or 'abnormal', and that that staff members' responses were not always compassionate (McCann, 2010a).

People expressed frustration that nurses could take issue with them engaging and being alone together in ward environments, even if the only intention was to socialise

(McCann, 2010a), and staff were viewed as having the right to intervene and prevent interpersonal relationships (McCann, 2000). Despite these obstacles, people talked about wanting support from staff to maintain relationships in the absence of other support or advice networks (McCann, 2010a). People tended to look to family members or friends (Östman & Bjorkman, 2013), as staff members were viewed as inaccessible in terms of talking about intimate relationships (Östman, 2014).

Institutional settings were also deemed inappropriate places to develop relationships because of the lack of privacy. Ward settings could be invasive places, with staff entering peoples' bedrooms without being invited (McCann, 2010a), and other service-users on wards could be curious to find out if relationships are developing (Redmond et al., 2010). People resorted to hiding their relationships from other service-users, or secretly met their partners in the hospital grounds for sexual encounters (McCann, 2000).

#### *Physical and psychological side effects of medication*

Although people described the therapeutic effects of medication in terms of managing symptoms of psychosis, the psychological and emotional consequences of unpredictable physical side effects affected people's sexual identity. Side-effects of medication included reduced or fluctuating sexual desire (McCann, 2010a; Östman, 2014; Volman & Landeen, 2007) ejaculation difficulties and impotence (McCann & Clark, 2004) and lack of physical flexibility in sexual movements (McCann, 2010a). Weight gain was a major issue (McCann, 2010a; McCann & Clark, 2004; Östman, 2014; Volman & Landeen, 2007) which had significant psychological consequences. People's body image was negatively affected by the weight gain (McCann, 2010a; Volman & Landeen, 2007) leaving them feeling unattractive. In some cases, people had found partners to share an intimate relationship with, but because both had gained weight because of medication it made sexual intercourse difficult physically (Östman, 2014).

Medication side-effects had psychological consequences which could be unpredictable, traumatising and frightening. Medication seemed to represent the 'elephant in the room'; one respondent commented that medication acted as a

constant reminder of mental illness, adding to the sense of a different identity (McCann, 2010a). Depot injections could affect moods and urges, causing libidos to raise and lower unpredictably or result in aversion to intimate contact (McCann, 2010a). Physical side effects could be traumatising and frightening, affecting people's sense of self and causing them to feel negatively about themselves (McCann & Clark, 2004). Lower libido and sexual urges impacted on people's sense of masculinity or femininity (Volman & Landeen, 2007). The effects of being unable to perform sexually made people feel so unattractive that efforts including make-up and new clothes did not help (Östman & Bjorkman, 2013).

## Discussion

The aim of this review was to synthesise qualitative literature on psychological and social barriers to accessing relationships for people with psychosis. Five themes emerged; though some themes diverge somewhat from the original research question, they were deemed highly valuable for the purposes of the review thus were included in the results. Nine studies were included in the review, with data from a total of 164 participants.

People with psychosis experience multiple psychosocial and emotional barriers to accessing relationships, as intimate relationships were viewed as being 'incompatible' with psychosis by some. Psychological effects were among the most prominent, and included significant impact on people's sexual identity, such that the 'sexual self' disappeared with the illness. Social relationships were often lost, and the emotional impact was clear throughout peoples' accounts, in terms of fear and shame, loneliness, social isolation and social anxiety. A key finding, and one requiring further exploration, relates to the psychological and emotional consequences of the sexual side-effects of anti-psychotic medication.

Stigma and rejection from the public and from prospective partners was evident in the experiences of people with psychosis, in addition to difficulties accessing support from family members and friends in discussing the difficulties associated with relationships. In addition, there appears to be paucity of resources and skills to support people to access relationships.

Intrapersonal issues reflected the private burden of people with psychosis that happen more 'behind-the-scenes' that might be highly distressing for individuals to address with health professionals, as difficulties in initiating discussions with professionals were evident. Alternatives to sexual contact included masturbation and paying for sex, but these were only accessed in the absence of having a relationship, and were associated with an emotional cost. Some participants mentioned the shame and embarrassment in seeking sexual contact with prostitutes or having to use masturbation as a substitute for an intimate partner.

Healthcare and institutional aspects also posed barriers to relationships for people with psychosis. A novel finding was that, although medication was recognised as an important aspect of treatment, the consequences of prescribed antipsychotic medication could be detrimental. The extra-pyramidal side-effects associated with antipsychotics had often severe physical impact, including weight gain and sexual dysfunction. The severity of the side-effects resulted in indirect, unpredictable psychological and emotional consequences. In addition to the emotional consequences of living with psychosis as an illness, participants felt that their sexual identities were further affected by feeling unattractive, traumatised and demotivated by medication.

Sexuality and intimacy appeared to be 'taboo' in inpatient settings, resulting in negative experiences of relationship support. Individuals felt unable to discuss sexual issues with psychiatrists because attitudes within institutions did not engender a sense of openness. Lack of consideration for intimacy needs was also present where service-users wished to interact in ward settings, and there appeared to be some frustration with mental health staff in relation to some of the practices in inpatient settings.

Many of the barriers to accessing and maintaining sexual and intimate relationships covered here could legitimately apply to people without mental health difficulties, as many people long for the right relationship that meets their needs and desires (e.g. Cramer, 2006; Sternberg, 1986). This simply highlights the stigmatising belief that people with severe and enduring mental health difficulties are in some way different (e.g. Buckley, Robben, Friedman, & Hyde, 1999). However, despite the often disturbing and distressing nature of their psychological experiences, people with psychosis continue to be sexual beings whose sexuality and intimacy issues are the same as those faced by the rest of the population in intimate relationships (e.g. Moreira, Glasser, Nicolosi, Duarte, & Gingell, 2008; Parmet, Lynn, & Glass, 2004; Watts & Stenner, 2005).

Findings converge with quantitative studies on the sexual and relationship experiences of people with psychosis. Sexual identity has been reported to change or diminish following the onset of psychosis, and sexual contact ceases for around

half of individuals (McCann, 2010b). Around one fifth of people with psychosis cite either lack of opportunities to develop intimate relationships or the illness itself as the main reason for the lack of sexual activity (McCann, 2010b).

Studies exploring long-term outcomes have demonstrated the importance of social relationships in coping with psychosis. Whereas social isolation predicts poorer levels of functioning, family support, positive relationships and social networks make a significant positive contribution to recovery (Albert et al., 2011; Harvey, Jeffrey, McNaught, Blizzard, & King, 2007). The experience of psychosis affects young people's social and emotional functioning in intimate situations, resulting in a lack of confidence to engage in dating and access relationships (Pillay et al., 2016).

These findings have implications for conceptualisations of recovery, specifically in terms of psychological processes that can impede the recovery process for people with psychosis. Psychological and social barriers to accessing relationships may in turn prevent people from accessing many of the core principles associated with recovery (Davidson et al., 2007). Accepting the loss of a previous self and exploring a new identity in the face of illness is an aspect of the recovery journey (May, 2004; Slade, Adams, & Hagan, 2012). Medication side-effects negatively impacted on sense of self, affecting people's masculinity or femininity, and new identities made people feel unattractive and self-critical. People described the stigmatising effect of psychosis, and their experiences from prospective partners as well as the public in their pursuit of intimate relationships, resulting in them feeling ostracised from the community. This could perpetuate negative stereotypes that people with psychosis engage in risky or deviant sexual behaviour (McCann, 2003). Stigma has significant emotional and social consequences (Buck et al., 2012) which need to be addressed in the context of supporting people with psychosis to access relationships such that it does not impact on recovery.

People with psychosis consider intimacy as more important than sexual contact. Earlier research has shown that social connectedness is fundamental to recovery (e.g. Drake & Whitley, 2014; Soundy et al., 2015), and the role of 'relational happiness' that involves relationships that foster hope and provide meaning in life. This review has highlighted the importance of meaningful sexual relationships for

people with psychosis, with a focus on a holistic view of sexuality which incorporates closeness, intimacy, shared experiences and support.

### *Clinical implications*

Mental health services are well-placed to assess the relationship and sexual needs of people with psychosis, and there is clearly a need for healthcare professionals to address such issues in routine practice (Gascoyne et al., 2016). Tools designed to support clinicians in addressing sexual relationship needs have been developed, including guidance on opening topics from a generic perspective, including on how to open conversations with clients (Stevenson, 2010). Assessment tools to address sexuality with clients include the BETTER model (Mick, Hughes, & Cohen, 2004), a structured approach to enable practitioners to address each area of need in a simplified, person-centred fashion and which can become part of embedded practice (Quinn & Happell, 2012a; 2012b). Each letter of the BETTER acronym represents a step in the discussion process which practitioners to address sexuality in an open and accessible way, including raising the issue of sexuality initially, explaining the importance of sexuality, discussing opportunities and limits on client's needs and providing psychoeducation around the adverse effects of treatment on sexual function (Quinn & Happell, 2012b).

Mental health settings draw on evidence-based psychological models including cognitive-behavioural therapy, systemic and third-wave cognitive approaches (Bird et al, 2010; NICE, 2014) which can be adapted to incorporate the emotional and psychosocial impact of psychosis on relationships. Intervention programmes could also incorporate social skills training for people with psychosis (Kopelowicz, Liberman, & Zarate, 2006). Case formulations that guide selected interventions will require discussions about stigmatisation, the emotional burden of psychosis and the individuals own beliefs and needs will have to be explored gently and with sensitivity. Clinical psychology is well-placed to address issues of sexuality, drawing on formulation skills that attend to complex needs (British Psychological Society, 2014) including sexual and relationships components (Sanger & Persson, 2014;

Stevenson, 2010).

### *Research recommendations*

Whilst some research has been conducted to explore the dampening effects of antipsychotic medication on cognitive and emotional functioning (Moritz, Andreou, Klingberg, Thoering, & Peters, 2013), no research to date has explored the psychological and emotional consequences of adverse physiological side-effects. Antipsychotic medication results in weight gain and sexual difficulties that impacts on individuals' capacity to access intimate relationships (e.g. Kelly & Conley, 2004). People experience low self-esteem and in some cases, traumatising effects of the physiological side-effects of antipsychotics. Research exploring these effects may enable practitioners to more easily assess for their impact and offer appropriate counselling and psychological interventions.

Resources have been developed to support healthcare professionals to initiate conversations about sex and intimacy (Mick, Hughes, & Cohen, 2004; Stevenson, 2010), however no specific assessment measures exist to assess such needs with people with psychosis. Specific assessment measures are needed based on the present findings that quantify the severity of sexuality and intimacy issues, including those related to personal barriers, institutional barriers, relationship-content barriers, support barriers and psychosis-related barriers.

Contextual factors such as the relationship difficulties of BME populations with psychosis or gender-specific barriers were not explored, and this may be in area for future research. Characteristics such as race, ethnicity and gender can cause people to avoid seeking psychological support (Vogel, Wester, & Larson, 2007; Paige & Mansell, 2013), thus further research could explore factors that can facilitate engagement.

### *Limitations*

This literature review has several limitations. Only a small number of studies were included, and because perspectives included were based on a limited number of



participants this may affect the generalisability of the review. Some of the studies included samples of less than ten participants, thus perspectives may not be shared by larger populations.

The review did not focus on specific barriers relating to gender or BME populations with psychosis, thus findings can only be generalised to the larger population of individuals with psychosis, rather than specific demographics. In addition, barriers that affect the development of relationships and those that impact on the maintenance of relationships were not delineated.

### *Conclusion*

This study provides evidence that psychosocial aspects of recovery should be emphasised in clinical guidelines for psychosis. Although current guidelines suggest recovery-focused care and the importance of social support in the stages following an episode of psychosis, there is no mention at present of the restorative effects of intimate relationships or the importance of including such a crucial aspect of the recovery process in interventions (NICE, 2014). Intimate relationships can promote hope, provide meaning and facilitate development of a new social identity in the stages following illness. To date, research linking intimate relationships and their role in the recovery process has been minimal (Boucher et al., 2016). Intimate relationships and healthy sexual relationships are central to many of the principles of the recovery process. This review has identified barriers to recovery which will enable health professionals to develop integrated approaches that focus on the most crucial psychosocial areas.

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## Appendices

### Appendix A. Quality Ratings of Included Studies.

Study	McCann (2000)	McCann and Clark (2004)	Hirschfeld, Smith, Trower & Griffin (2005)	Volman & Landeem (2007)	McCann (2010a)	Redmond, Larkin and Harrop (2010)	Östman and Björkman (2013)	Ostman (2014)	Boucher, Grouleau, & Whitley (2016)
1. How credible are the findings?	2	3	4	4	4	4	3	2	3
2. How has knowledge/understanding been extended by the research?	2	2	3	3	3	4	4	2	2
3. How well does the evaluation address its original aims and purpose?	3	3	4	3	3	4	3	2	2
4. How well is the scope for drawing wider inference explained?	3	2	4	2	2	4	4	2	2
5. How clear is the basis of the evaluative appraisal?	1	2	4	3	1	4	1	2	2
6. How defensible is the research design?	2	2	4	4	2	3	3	2	1
7. How well defended is the sample design/target selection of cases/documents?	2	3	3	4	3	3	2	3	2
8. Sample composition/case inclusion - how well is the eventual coverage described?	2	2	2	3	2	2	1	3	2
9. How well was the data collection carried out?	2	3	4	3	3	4	3	3	3
10. How well has the approach to, and formulation of, the analysis been conveyed?	1	3	4	4	2	4	2	2	3
11. How well are contexts of data sources retained and portrayed?	2	2	3	4	2	3	2	2	2

12. How well has diversity of perspective and content been explored?	2	4	4	3	3	3	3	2	2
13. How well has detail, depth and complexity (richness) of the data been conveyed?	2	3	4	4	3	4	2	2	3
14. How clear are the links between data, interpretation and conclusions - how well can the route to the conclusions be seen?	1	3	4	3	3	3	2	2	2
15. How clear and coherent is the reporting?	1	3	4	3	4	4	3	2	3
16. How clear are the assumptions/theoretical values that have shaped the form and output of the evaluation?	2	2	4	2	4	3	2	2	2
17. What evidence is there of attention to ethical details?	1	2	1	2	4	4	2	3	2
18. How adequately has the research process been documented?	2	2	3	2	2	2	2	1	1
Total average	2	3	4	3	3	3	2	2	2
Total summed	33	46	63	56	50	62	44	39	39

Appendix B.  
Thematic synthesis example.

Code	Data extract example	Third order analysis	Theme
Difficult relationships can add to the level of distress, feeding into the psychosis	Narrative: difficult relationships prevent recovery	<p><b>Perhaps there is a fear there that previous relationships have led to or affected the illness, therefore there is a reluctance to even try. At the same time there is a conflict as people realise it may help them, as long as the relationship is good</b></p>	Barriers to recovery
Lack of relationships prevent the ability for people to recover fully	<p><i>If I had a boyfriend, maybe I would recover fully.</i></p> <p><i>I'm tired of being alone.</i></p>		
It is the quality of the relationship in addition to the relationship itself that predicts recovery	<p><i>I enjoy my relationship, but it's different.</i></p> <p><i>There are different relationships - the person before me ruined me.....</i></p>		
(overarching theme: psychosis can affect relationships negatively)			
Symptoms such as hallucinations and delusions impact on relationships	<p><i>Sometimes you are somebody else. I thought my husband was somebody else, I was screaming at him'</i></p>	<p><b>Perhaps there is an additional psychological barrier here...if people behave certain ways in relationships they may avoid them. They may also fear how they may react if they become unwell.</b></p>	Relationships incompatible with psychosis
(overarching theme: ability/inability to meet potential or suitable partners)			
Lack of social networks		<p><b>Reluctance to even try and form a relationship if there are practical barriers there - I don't have any money to take a girl out therefore why is she going to be interested in me?</b></p> <p><b>People have failed before they have even tried</b></p>	Lack of skills and resources to develop relationships
Not working/unemployed			
Opportunities to meet people	<p><i>If I do meet a girl, how am I going to take her out? How do you do it with no money</i></p>		
Lack of financial support			
(overarching theme: psychological barriers)			

People's experience of stigma	<p><i>If they hear you have a mental illness, forget it. They run the other way!</i></p> <p><i>I was happy with someone and he found my medication - I never heard from him again!</i></p>	<p><b>Again, reluctance to try because of the fear of 'what's out there' - people who don't care, people who will reject you, people who don't understand</b></p> <p><b>People may have experienced traumatic relationships that confirm their fears - been rejected, faced with someone who runs away</b></p>	Stigma and rejection
Finding someone suitable	<p><i>I don't want to be with another service user! But then how do you find someone who is well and wants to be with someone who isn't?</i></p>	<p><b>There may be a sense that if you have experienced psychosis you can't set reasonable precedents about what YOU want from a relationship...security, stability...do you have to settle for what you can GET?</b></p>	Fears about relationship content and expectations
(overarching theme: practical and institutional barriers)	<p>Narrative: people not being allowed to have relationships on wards prevents the ability to develop relationships</p> <p><i>People end up having sex in bathrooms!!</i></p>	<p><b>Because of the lack of understanding in institutional settings, people will either avoid having close relationships or go to great, often uncomfortable lengths to try and have them!</b></p>	Lack of support from healthcare staff and institutions
Internal/institutional regulations Lack of private space			

## **Chapter 2: Empirical Paper**

**Clinical psychologists' views about talking  
to people with psychosis about sexuality and intimacy:  
A Q-methodological study**

**Word count: 8, 289**



## **Abstract**

Sexuality and intimacy are often overlooked in the lives of people with psychosis, yet intimate relationships provide psychosocial benefit, facilitate recovery and reduce the risk of relapse. Although mental health professionals may avoid initiating conversations about sexuality and intimacy with service-users for a variety of reasons, people with psychosis and their support networks have indicated their desire for professionals to address intimate topics. Clinical psychologists working with people with psychosis are trained to address complex needs, however no research to date has explored their views about talking to clients about sexuality and intimacy. Q-methodology was used to explore clinical psychologists' personal and professional views about discussing sexuality and intimacy with people with psychosis. 27 clinical psychologists completed Q-sorts. Varimax rotation revealed three factors with distinct views, including a majority perspective that highlighted the normality of sexuality and intimacy for people with psychosis and the acceptability of such conversations in clinical work for practitioners. Further views focused on concerns about the appropriateness of addressing sexuality with clients and the possibility that conversations could lead to increased risk, and a view that related to concerns about clinical psychologists' competence in addressing intimate subjects. The practical and clinical implications are discussed in terms of training need and limited access to sexual health services.

## Introduction

### *Psychosis, sexuality and intimate relationships*

Psychosis is a complex, socially debilitating condition, associated with a loss of friendship networks (Harrop, Ellett, Brand, & Lobban, 2015), social isolation (Broome et al., 2005) and difficulties developing and maintaining intimate relationships (McCann, 2003). Stigma and prejudice increase the risk that the relationship needs of people with psychosis are marginalised (McCann, 2003), as stereotypes portray individuals with mental health difficulties as engaged in risky or deviant sexual behaviour (Buckley, Robben, Friedman, & Hyde, 1999). People experiencing psychosis have often survived sexual abuse or trauma, and the emotional consequences of these experiences can prevent people from accessing support (McCann, 2010b). The personal burden of low self-confidence, low self-esteem and lack of self-care on people suffering with psychosis often reduce the likelihood that they will seek help with sexual issues (Quinn & Happell, 2012b).

Intimate relationships are crucial to individual quality of life, embodying experiences on physiological, psychological and social levels (Tierney, 2008). Policymakers highlight sexuality as a fundamental aspect of human life, and argue that we should be free to make choices about relationships without stigma or prejudice, regardless of disability or illness (Department of Health, 2013). Organisations in the United Kingdom and abroad have recently set out agendas for developing sexual health and sexual needs, stating that from a human rights perspective, every individual is entitled to access to information and services to promote sexual health (WHO, 2015). However, the sexual and intimate relationship needs of service-users are rarely addressed in mental health services (McCann, 2010a).

A major issue contributing to the complexity around sexual issues in psychosis is the impact of drug treatments. Anti-psychotic medication is often prescribed as a first-line treatment for psychosis (NICE, 2014), and it can provide relief from distressing symptoms (e.g. Leucht, Corves, Arbter, Engel, & Davis, 2009). These drugs have well-documented adverse physiological side-effects that affect sexual functioning, however (Baggaley, 2008), experiences which can be psychologically traumatising

and which impact detrimentally on one's self-image (Southall, 2017). Despite the awareness of the sexual side-effects of medication, mental health professionals rarely assess their impact with service-users (Gascoyne, Hughes, McCann, & Quinn, 2016). (A review of the literature relating to psychosocial barriers to sexuality and intimacy is provided in Paper 1).

### *Provision of psychosocial support for people with psychosis*

Evidence for leading psychological treatments for psychosis is not encouraging and presents a mixed picture in terms of the effectiveness of different approaches (Goldsmith, Lewis, Dunn, & Bentall, 2015; Jauhar et al., 2014; Piquart, Oslejek, & Teubert, 2016; Taylor & Perera, 2015). In addition to traditional treatments such as cognitive-behavioural therapy and medication, NICE guidelines recommend person-centred care packages and a focus on recovery approaches that include social rehabilitation (National Institute for Health and Care Excellence [NICE], 2014). Recovery-focused approaches encourage service-users to take responsibility for their own mental health, conceptualising the process of overcoming mental health difficulties as a journey that incorporates a variety of principles that mental health professionals can provide support with (Leamy, Bird, Le Boutillier, Williams, & Slade, 2011). Principles include a focus on finding meaning in life, positive social support networks and the development of new identities (Davidson et al., 2007).

Research describing positive elements of the recovery journey for people with psychosis has demonstrated the restorative effect of close personal relationships (Davidson et al., 2007; Drake & Whitley, 2014; Soundy et al., 2015; Tew et al., 2012). Social support can promote psychological wellbeing (Pruessner, Iyer, Faridi, Joobar, & Malla, 2011), with intimate relationships acting as a buffer against the psychological stress of coping with psychosis (Gayer-Anderson & Morgan, 2013) and predict better long term outcomes for sufferers (Tew et al., 2012). Mental health services may need to broaden their approach to support people with unmet needs and with greater focus on social aspects of recovery models. Recent meta-analyses have suggested that interventions that aim to support people with psychosis in

developing social skills may produce positive outcomes in terms of reduced relapse and rehospitalisation, and promote quality of life (Almerie et al., 2015).

People with psychosis are often unable to access positive social networks and support in developing intimate or romantic relationships (Gascoyne, Hughes, McCann, & Quinn, 2016; Östman & Bjorkman, 2013; Pillay, Lecomte, & Abdel-Baki, 2016). Paradoxically, psychosocial factors such as independent living, social contact and being in a relationship significantly predict recovery from psychosis (Albert et al., 2011; Onken, Craig, Ridgway, Ralph, & Cook, 2007). People with psychosis highlight sex and intimacy as a key area of need, in comparative terms of importance as physical health and housing (Fleury, Grenier, Bamvita, & Tremblay, 2012). Sexual expression and intimate relationships are also reported as an area of concern by families of individuals with psychosis (Iyer, Loohuis, Pawliuk, Joober, & Malla, 2011) and mental health staff (Hensel, Banayan, Cheng, Langley, & Dewa, 2016). Crucially, service-users have also expressed their desire to discuss sexuality and intimacy, and look to mental health professionals to initiate discussions (McCann, 2000).

### *Professionals' roles in addressing sexuality and intimacy*

Reluctance to discuss sexuality and intimacy amongst health professionals is a current challenge. Quinn, Happell and Browne (2011) identified factors explaining why mental health nurses avoid discussions around sexuality with service-users, including beliefs that sexuality is “not important” and that talking about sexuality is “not part of their role”. Healthcare professionals may also avoid the topic because of concerns about their proficiency in dealing with the subject matter, time constraints or embarrassment and personal discomfort (Dyer & das Nair, 2012). Resources have been developed to support healthcare professionals in opening dialogues on sexuality with service-users (Butler, O'Donovan, & Shaw, 2010; Mick, Hughes, & Cohen, 2004; Quinn & Happell, 2012a).

Little is known about the views and attitudes of clinical psychologists around discussing issues of sexuality and intimacy with people with psychosis. Whilst

studies have explored issues in nursing practice around sexuality and intimacy, clinical psychology has yet to examine its views and practices. Clinical psychology training equips practitioners with advanced communication skills to provide competent and effective assessment, formulation and intervention to people with severe mental health difficulties (British Psychological Society, 2014; Division of Clinical Psychology, 1995). Those undertaking doctoral courses in clinical psychology are trained to employ their skills to explore complex issues with clients (Onyett, 2007; Division of Clinical Psychology, 2010). Reluctance to address sexuality and intimacy amongst clinical psychologists may be linked to lack of training (Miller & Byers, 2010; Reissing & di Giulio, 2010) or concerns about competency (Miller & Byers, 2012), particularly for those who have recently qualified (Sanger & Persson, 2014).

### *Aims*

In the context of current research exploring the role of mental health professionals in discussing the sexual and intimate relationship needs of people with psychosis, the views of practicing clinical psychologists in assessing this complex area is unclear. This study uses Q-methodology to explore clinical psychologists' multiple subjective views on discussing issues of sexuality and intimacy with people who experience psychosis.

## Method

### *Overview of Q methodology*

Q-methodology is a unique methodological tool which captures participants' subjective views in a systematic fashion (Brown, 1993). The approach was developed by William Stephenson (1935, cited in Watts & Stenner, 2012) as a method for exploring *operant subjectivity* – individuals' subjective viewpoints on naturally occurring phenomena (Brown, 1980).

Q-methodology embraces both quantitative analysis and qualitative procedures. The qualitative aspect requires participants to assign meaning to a collection of pre-assigned statements by ranking them in a forced distribution along a continuum, e.g. from Most Disagree (-6) to Most Agree (+6). By-person factor analysis then enables statistical exploration of similarities and differences between groups of shared perspectives (van Exel & de Graaf, 2005). Unlike typical factor analysis, where correlations are made between outcomes on given tests or variables, Q-methodology correlates participants, such that they represent the variables being studied.

### *Epistemological position*

The researcher adopted a social constructionist epistemological stance for the purposes of this study. Social constructionism refutes the existence of singular truths adopted by other methodological approaches and assumes that multiple perspectives of experiences can exist (Braun & Clarke, 2013). Social constructionist perspectives assume that views of the world are influenced by language as well as sociological, political, historical and other contextual factors (Burr, 1995).

Q-methodology embraces the epistemological position of social constructionism as the different perspectives equate to the different subjective viewpoints produced by the analysis. Different factors represent perspectives based on different constructions of the world through social experience, whereas individual factors

represent shared viewpoints of participants in terms of the meaning they assign to statements (Watts & Stenner, 2012).

### *Development of the Q set*

The first phase of the Q-sort is the development of the Q-set, the collection of statements that are presented to participants to rank. A rigorously developed Q-set should incorporate all possible views that the participant population could hold about the subject area. A Q-set of between 40 and 80 statements is considered appropriate (Eccleston, Williams, & Stainton Rogers, 1997).

The statement concourse was developed by means of a review of relevant literature. A diverse range of literature was reviewed, including books and articles on psychosis and schizophrenia, sexuality and intimacy, recovery, psychosocial needs of people with severe mental health difficulties, clinical psychology practices and training, stigma, and health professionals' attitudes to talking about sexuality.

Five psychologists working within the NHS (Four clinical psychologists and one counselling psychologist) representing a diversity of professional experience were also invited by email to contribute ten items to the Q-set. Duration of experience as qualified psychologists ranged from less than one year post-qualification to twenty-six years' experience. Psychologists worked in a range of different settings, including older adults, clinical health psychology, adult mental health and adult learning disabilities and all employ integrative psychological approaches, drawing on cognitive-behavioural and third-wave CBT, schema-focused therapy and community psychology. Each psychologist was sent an email describing the research question, a description of Q methodology and an invitation to suggest ten statements relating to the subject area (see Appendix S).

Statements were reviewed by a Q-methodology research interest group comprising trainee clinical psychologists and a senior lecturer at Staffordshire University. Further checks were made by a Consultant Clinical Psychologist working predominantly with adults with psychosis and service-user with lived experience of psychosis. This resulted in a total concourse of 66 statements which are shown in Appendix T.

### *Ethical approval*

This study was subject to ethical approval by Staffordshire University Research Ethics Committee (Appendix C). R&D approval was also granted by two NHS trusts in the West Midlands (Appendix D).

### *Participants*

Large participant groups (P-sets) are not required to produce meaningful results in Q-methodology (Watts & Stenner, 2005). Guidance in the literature for determining appropriate P-sets varies; some researchers recommend less than the number of items in the Q-set or half as many participants as a study has statements (Watts & Stenner, 2012). Small numbers of participants are deemed acceptable though, and Q-sort papers are published with less than 30 participants (e.g. Flitcroft, James, & Freeston, 2007; Dudley, Siitarinen, James, & Dodgson, 2009; Orchard, Fullwood, Morris, & Galbraith, 2015).

27 clinical psychologists participated in the study. Participant demographics are detailed in Table 2.1. Inclusion criteria required all participants to be qualified clinical psychologists working in the NHS in England in either a community or inpatient setting with people with psychosis. A purposive sampling approach was primarily used to ensure viewpoints were gathered from clinical psychologists from different geographical locations. To recruit further numbers of participants, snowball and convenience sampling was also necessary. Clinical psychologists currently working with people with psychosis were recruited directly by email. Other clinical psychologists were then recruited indirectly by people who had participated.



Table 2.1. Participant demographics

	Number of participants
Gender	
Female	21
Male	6
Age group	
30 – 34	8
35 – 39	5
40 – 44	8
45 – 49	3
50 – 54	2
55 – 59	1
Location	
East Midlands	1
West Midlands	22
South East	1
East of England	1
North East	1
North West	1
Years since qualification	
1 – 4	12
5 – 9	6
10 – 14	4
15 – 19	3
20 – 25	1
25 +	1
Years in current post	
Less than 6 months	2
6 months – 1 year	4
Over a year	5
2 – 4 years	7
5 – 9 years	5
10 – 14 years	3
15 + years	1

Current professional role		
	Clinical psychologist	9
	Senior clinical psychologist	7
	Consultant/Principal clinical psychologist	10
	Did not state	1
Service setting		
	Inpatient	6
	Community	16
	A combination of both	5

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A recruitment advert was also placed for one issue of the British Psychological Society monthly publication *The Psychologist* (see Appendix L). Eight participants provided data in the form of physical Q-sorts, and the remaining 19 were collected using the POETQ online system (Jeffares & Dickinson, 2012).

### *Procedure*

*Physical Q-sorts.* Each participant was provided with a printed A4 sheet depicting the condition of instruction (Appendix N) and the shuffled Q-set statements that were printed on laminated cards approximately 8cm x 5cm. Participants were asked to read each statement and form three separate piles representing 'Agree' 'Disagree' or 'Neutral/Indifferent' responses to each. At the point of completion, participants were introduced to the distribution grid which consisted of a 13-point scale from -6, representing the response 'Most Disagree' to +6 representing 'Most Agree' (Figure 2.1). Participants were invited to provide verbal feedback during the Q-sort, and were interviewed briefly to provide further feedback after the study was complete. (Appendix G).



## Results

### *Analysis*

Data from 27 completed Q-sorts were analysed using the dedicated Q analysis package PQMethod (Schmolck, 2014). The analysis process initially seeks to identify correlations between Q-sorts, and factor analysis subsequently provides a statistical analysis of Q-sorts with the highest intercorrelations. Each factor is a statistical grouping of participants that have arranged Q-sorts in similar ways, thus representing a shared viewpoint within a subgroup of participants.

A centroid factor analysis with Varimax rotation was used, and applying the Kaiser-Guttman principle of accepting only factors with Eigenvalues greater than 1.00 (Brown, 1980), three factors were extracted accounting for 76% of the study variance. All factors contained more than one significantly loading factor at a level of  $p < .01$ .

Q-sorts were selected and 'flagged' for inclusion in each factor. PQMethod provides an option for representative Q-sorts to be automatically selected based on two criteria: that the loading is significantly high ( $p < .05$ ), and that the squared loading is higher than the sum of the square loadings for all other factors (Brown, 1980; Zabala & Pascual, 2016). Although in this case automatic flagging was used, Q-sorts can also be manually flagged by determining high loading cases that do not confound with other factors (Watts & Stenner, 2012). Rotated factor loadings are shown in Table 2.2. The correlation matrix between Q-sorts is shown in Appendix P.

Table 2.2.  
Rotated factor matrix showing factor loadings.

Participant	Factor 1	Factor 2	Factor 3
1	0.5967X	0.3617	0.4726
2	0.6362X	0.586	0.1164
3	0.8000X	0.2051	0.2252
4	0.3861	0.6071X	0.2709
5	0.5558	0.6185	0.3527
6	0.5217	0.5872	0.3386

7	0.7715X	0.2916	0.2881
8	0.5809	0.6071	0.3036
9	0.2337	0.5682X	0.5095
10	0.8219X	0.4041	0.0908
11	0.8882X	0.2024	0.021
12	0.2018	0.4172	0.7410X
13	0.1686	0.3167	0.8126X
14	0.0258	0.7762X	0.3814
15	0.7759X	0.296	0.2476
16	0.3877	0.7629X	0.3375
17	0.6764X	0.5783	0.1733
18	0.8062X	0.3317	0.1874
19	0.264	0.3617	0.7500X
20	0.4688	0.4127	0.5178
21	0.6376X	0.4414	0.2181
22	0.7560X	0.2755	0.379
23	0.4508	0.7230X	0.3063
24	0.6297X	0.5111	0.3444
25	0.7604X	0.0547	0.4835
26	0.3079	0.6979X	0.312
27	0.6853X	0.2186	0.5208

### *Arrangement of factor arrays*

Straightforward interpretation of each factor is facilitated by listing the arrangement of statement rankings within each factor to create factor arrays. The factor array is produced by weighting the Q-sorts that load significantly on each factor. The individual ranking of each statement can be listed and an exemplifying Q-sort produced. 23 of the 27 Q-sorts loaded significantly onto factors. Confounding or non-significant Q-sorts were excluded from factor arrays. Statements that were statistically significant by 3 standard deviations are classed as distinguishing between other items at  $p < .01$  (Brown, 1980) and were given priority in the factor arrays followed by those with a significance level at  $p < .05$ . Consensus statements were excluded from factor interpretations.

### *Factor interpretations*

Though factor arrays are a relatively accessible depiction of ranking of items and the statistical significance of items within each factor, further strategies can be adopted to facilitate a more detailed interpretation of the viewpoint. The development of 'crib sheets' allows the researcher to systematically explore the context of each factor whilst maintaining a holistic view of the factor (Watts & Stenner, 2012). The crib sheet includes the statements at the highest and lowest rankings in the array, thus items at +6, +5, -6 and -5 were included. In addition, a further process involves listing *items ranked higher* and *items ranked lower* for that factor. Additional items can be added to the interpretation as it evolves. Crib sheets are shown in Appendix K. A final step in the interpretation process is the creation of factor exemplars, which are visual depictions of the representative Q-sort with each item placed in its place within the distribution. Factor exemplifying Q-sorts are shown in Appendix H - J.

### *Findings*

The description of each factor is provided in narrative form along with the corresponding statement number and its ranking within the factor (e.g. 17, +5) to show the significance of each item and the viewpoint it represents (Watts & Stenner, 2005). Qualitative comments provided by participants are also included within the narrative to provide further depth.

*Factor A: The sexual and relationship needs of people with psychosis are the same as everyone else's, and it is our duty to talk about them*

Factor one had an eigenvalue of 9.45 and explained 35% of the study variance. 14 participants (Participants 1, 2, 3, 7, 10, 11, 15, 17, 18, 21, 22, 24, 25 and 27) significantly load on this factor. 12 participants were female, 2 were male. 5 were employed in the position of Clinical Psychologist, 3 in the position of Senior Clinical Psychologist and 5 in the position of Consultant/Principal Clinical Psychologist. 1 participant did not disclose their position. The mean number of years since qualifying as a clinical psychologist was 7 years 2 months, and the mean number of years in

present post was 5 years 4 months. The mean proportion of clinical time spent working with people with psychosis as part of their role was 62%.

A distinguishing positive statement for this account indicated that participants rated the importance of sexual expression highly in the lives of people with psychosis (21, +6), a perspective that was supported by views that not supporting people with psychosis to access relationships *'would be bizarre'* (Participant 15). Many participants expressed how strongly they felt that it is clinical psychologists' duty to address such a fundamental human issue that *'can so easily be overlooked'* (Participant 7). Participant 17 highlighted the *'need to acknowledge the relevance and importance of sex and intimacy in people's lives. We can't pretend it doesn't exist'*.

It is important for these participants to open conversations about sex and intimacy in clinical settings because they recognise the link between intimate relationships and people's identity (59, +6). As Participant 10 stated, conversations about sex and intimacy *'play a crucial role in how people live and manage relationships effectively'*. Supporting statements suggested that sex and intimacy would not be avoided with clients, and that it would be an acceptable topic to address in a therapeutic setting (47, +4). Participant 15 highlighted that *'In order for therapy to be effective we ought not to occlude any areas of normal human life, including sex and intimacy'*. Furthermore, although these participants may cover many important topics with their clients, they also would not avoid conversations that focused on more intimate needs (2, -1).

Participants also endorsed the belief that discussions around sex and intimacy should be acceptable in therapeutic work (35, +4), and Participant 2 supported this with a statement that disclosures of a sexual nature that a client finds emotionally difficult to talk about *'can enable truly therapeutic work to happen'*. The therapeutic process involved in engaging in discussions about sex and intimacy may be facilitated by the opportunity to normalise their needs and desires (38, +5). Participants also recognised that discussions about sex and intimacy can help achieve many of the core goals of therapy, specifically promoting trust and developing the therapeutic relationships (20, +1; 61, +2), facilitating greater social

support for the client (22, +2) and engaging in work to reduce the likelihood of relapse (23, +2).

For these participants, an understanding of the relationship needs and perceived barriers for their clients are important as part of the assessment process in terms of ensuring that a good understanding has been reached (36, +4). Such a conversation should not be avoided, as clinical psychologists may miss opportunities to explore issues relating to a client's experience that have contributed to the current difficulties (37, +2). The clients' current relationship status affected the likelihood that these participants would initiate conversations about difficult topics with clients (8, 0).

There are no concerns about the perceived competency of these participants in relation to raising discussions around the sexual and intimate relationship needs of people with psychosis (43, -5), and although it can be perceived as being a sensitive topic it can be addressed with the client (29, +1). Participants feel that the skills and training they already have are sufficient to ensure a comfortable discussion with clients (40, -4), and that doctoral training should provide clinical psychologists '*with the ability to talk about every subject relevant to human experience. Sex is just another aspect of human experience*' (Participant 11). There were minimal concerns that sexuality and intimacy is an uncomfortable topic for clinical psychologists to discuss (42, -3).

Participants recognised that there are inherent risks in opening conversations about sex and intimacy, but this did not mean that there was a sense that this risk was a reason to avoid the topic (63, 0). These participants are aware that there is a level of complexity in raising topics of such a sensitive nature with clients with psychosis, but any challenges around this can be managed (41, -3) as it is the role of the clinician to explore and manage complex issues (Participant 11).

### *Summary of Factor A*

Participants in this account strongly believe that it is their role to ask clients with psychosis about sexual and intimate relationship needs. This is supported by perspectives that sexuality is a human issue, fundamental to human functioning,



playing a role in how people live their day-to-day lives. The role of sexuality and intimacy could play a central role in clinical work for these participants alongside other therapeutic issues. Understanding the relationship needs of their clients allows these participants to develop a thorough understanding of their clients. Conversations about sexuality and intimacy facilitated by these clinicians appear to promote the therapeutic relationship and allow the client to work through emotionally difficult issues in terms of intimate relationships.

*Factor B: I would talk to people with psychosis about sex and intimacy, being mindful of the possible risks and concerns*

Factor B has an eigenvalue of 6.48 and explains 24% of the study variance. 6 participants (Participants 4, 9, 14, 16, 23 and 26) significantly load on this factor. 4 were female, 2 were male. 2 were employed in the position of Clinical Psychologist, 2 in the position of Senior Clinical Psychologist, and 2 in the position of Consultant/Principal Clinical Psychologist. The mean number of years since qualifying as a clinical psychologist was 7 years 4 months, and the mean number of years in present post was 3 years 2 months. The mean proportion of clinical time spent working with people with psychosis was 50%.

This factor emphasised participants' concerns around the appropriateness of engaging in discussions about sex and intimacy with clients with psychosis. Participants contributing to this factor were mindful that a conversation about sex and intimacy might be an important factor within their clinical work, but where there was a *need* to assess the potential issues rather than to explore needs and desires (1, +6), as Participant 4 stated '*I'd need to if it was part of the client's difficulties or increased their risk profile in some way*'. For this reason, it was not considered necessary to engage in a conversation about sex and intimacy, as acceptable clinical work could be undertaken without such a conversation taking place (36, -3). Participants were ambivalent about talking about sex and intimacy, and although they would not discourage or avoid a conversation about sex and intimacy, they

would not initiate such a conversation if it was not necessary for their work with that client (48, 0).

Concerns about the appropriateness of initiating conversations about sex and intimacy in clinical settings were clear, and this was supported by views that assessment and intervention may not include such a conversation if the focus was on more important issues (2, +3). Participants are aware that a conversation about sex and intimacy might not be appropriate for various contextual reasons (28, +5), as Participant 9 stated “...it can be seen as inappropriate or not something you should talk about with people you don’t know...”. This view was echoed by a concurrent perspective that people with psychosis may not want a clinical psychologist to initiate such a conversation (16, +5).

These participants would decide on whether to raise conversations about sex and intimacy with a client based on background information relating to each client, as contextual factors relating to the specific needs and difficulties of a client seemed to determine the likelihood of whether a conversation about sex and intimacy would occur in a clinical setting. Risk management was at the forefront of concerns for these participants. There was an awareness that discussing intimate topics may increase the risk of harm to the client themselves or to others (66, +4). Participants were also concerned about the potential for clients to act unpredictably or place themselves in danger following a conversation about sex and intimacy (65, +3).

A conversation about sex and intimacy might also not be possible if clients have little knowledge about sex and relationships (31, +3), as Participant 26 stated “A number of clients are unsure about sex”. These participants would make informed decisions about any adverse factors that could exacerbate existing difficulties a client might present with when considering whether to initiate conversations about sex and intimacy with clients. Although the client’s level of social isolation would not necessarily preclude discussions of sex and intimacy, practitioners would be mindful of the impact of a conversation (26, +1), perhaps because of the possible impact of loneliness on the client’s level of distress (53, -1). In terms of clinical work and the progress of therapy, such a discussion may cause otherwise avoidable negative consequences, such as ruptures to the therapeutic relationship (62, +4), as

Participant 14 commented: *“If my client misinterpreted my interest this would disrupt the therapeutic alliance considerably and may contribute to complex transference.”*

These participants expressed strong views that the process of engaging in a conversation that involved sex and intimacy might not be a straightforward process in a clinical setting, and the possibility that such a conversation might be a challenging experience would again depend on the specific needs of the client (29, +6). Participant 16 supported this with the statement *‘sex is not something we generally talk about publicly as we might some other things, so we have to recognise that this might be particularly embarrassing, more or less so depending on their own reference points’*. However, despite the recognition of important contextual factors that these participants would hold in mind when engaging with clients about sex and intimacy, the potential for distress is not solely a reason to exclude such conversations if there was a need (52, +2).

#### *Summary of Factor B*

Participants providing Q-sorts in Factor B focused on the clinical and risk management issues in discussing sexuality and intimacy with clients with psychosis rather than on exploring sexual relationship needs and desires. Conversations about intimate relationships were not encouraged, and there was a sense that acceptable clinical work could be undertaken without such a conversation taking place. Issues relating to the individual profile and need of each client influenced whether participants would initiate conversations about sexuality, such as the level of risk presented by the client, level of social isolation and knowledge about sexual matters. There were concerns about the impact on the therapeutic relationship if the client’s misinterpretation of the conversation led to confused boundaries.

*Factor C: People with psychosis should be able to talk about sex and intimacy, but perhaps not with me*

Factor B has an eigenvalue of 4.59 and explains 17% of the study variance. 3 participants (Participants 12, 13 and 19) significantly load on this factor. 2 were female, 1 was male. 2 were employed in the position of Clinical Psychologist and 1 in the position of Senior Clinical Psychologist. The mean number of years since qualifying as a clinical psychologist was 2 years, and the mean number of years in present post was 1 years 1 month. The mean proportion of clinical time spent working with people with psychosis was 27%.

This account conveyed participants' mixed views about the prospect of including discussions about sex and intimacy in work with people with psychosis. There were positive views that people with psychosis *should* be able to talk to professionals about intimate topics, but such conversations may be best addressed by other professionals. These participants believe that they should be available to talk about sexual and relationship needs with people with psychosis (15, +6). Participants recognise that the relationship needs of people with psychosis and the rest of the population do not differ (3, +5), and there is a strong belief that a conversation about sex and intimacy would not impact negatively on clients, and may even result in positive outcomes (53, +4). These participants clearly do not hold the view that sexuality and intimacy is a priority topic that therapist and client can comfortably address in clinical psychology sessions (59, -1). They may initiate such conversations, but only as a necessity if the client wished to address it (21, 0), as Participant 13 commented *'It is generally a topic which seems to be avoided by other disciplines in mental health services and yet it is a significant part of people's lives. Someone has to be available to talk with clients about these things if they wish to do so'*.

Several statements in factor three indicated that ambivalence about addressing intimate topics was related to participants' perceived skills in this area. Conversations about sex and intimacy are apparently an area that would cause some concern for participants, as a distinguishing statement indicated that such topics may be too complex for them to appropriately manage in sessions with clients (41, +6). Such fears may be linked to a gap in training at doctoral level to engage

with clients about their intimacy needs (40, +6), as Participant 13 commented that *'for such a complex and immense topic, there was very little in the way of training...'*. The absence of appropriate training or adequate experience in clinical issues in sexuality and intimacy causes these participants to doubt their competency in initiating conversations about intimate topics with clients (43, +2).

Reluctance to engage in conversations about sex and intimacy suggested by factor two also highlights occasions where it may be a necessary subject, there may be specific circumstances under which clinicians do and do not explore such sensitive issues. Referrals may be made to other professionals, or conversations limited in clinical psychology sessions (2, +3), as *'it is not necessarily part of my role'* (Participant 12). Participants may not choose to discuss sexuality from the perspective of exploring the client's relationship needs or desires, but instead focus on management of other issues such as minimising distress for the client (47, -2). Where it is not essential, a risk assessment with a client with psychosis may not even include issues relating to sex and intimacy (5, +2). An example of a factor that would initiate a conversation about sexual experiences might be in response to a client's disclosure that they have been subject to sexual abuse (6, +3), or if the client wishes to discuss their sexual needs and no other professional has engaged in such a conversation with them (19, +3). Even if a client was already in a relationship, participants may not open discussions about sex and intimacy (8, -3).

This factor revealed awareness that a conversation about sexuality and intimacy that was not conducted skilfully might result in difficulties when working with clients. One issue at the forefront of these participants' thinking was that sexual and intimacy issues may be very difficult matters for a client to discuss with a clinical psychologist (29, +5). Participants are mindful that there may be emotional consequences too (30, +2). Although clinical psychologists are skilled in managing emotionally difficult conversations in general, the possible distress of talking about sex and intimacy needs to be considered before a conversation is initiated (28, +5). Conversations may trigger difficulties for the client (18, -1) resulting in ruptures in the therapeutic relationship and the client feeling less able to talk openly about their difficulties, therefore *'being mindful of this means taking time so they can build a trusting relationship with me'* (Participant 13).

### *Summary of Factor C*

Whilst agreeing that sexuality and intimacy was a topic that people with psychosis should be able to address with clinical psychologists, participants in Factor C did not feel comfortable undertaking such a conversation themselves. There was a sense that a conversation would take place only if it was necessary, for example in the absence of a more qualified or experienced professional. Participants also doubted their competency in talking about intimate topics, the result of a lack of doctoral training around sexuality and intimacy, and were mindful of the potential distress of discomfort that could result in a conversation not conducted sensitively.

#### *Consensus statements*

Consensus statements are non-distinguishing items that participants all rank similarly and which tend to show similar rankings across all factors (van Exel & de Graaf, 2005). There were 21 consensus statements, which represents agreement on 32% of items in the Q-set. They have been grouped into two perspectives.

The first consensus perspective contained 8 statements, and reflected agreement on the role of the clinical psychologist to consider complexity and be respectful in clinical work with people with psychosis. Clinical psychologists should consider the emotional challenges that might be associated with talking about sexuality and intimacy (30), and be mindful that personal characteristics of each client might impact on such a conversation, such as previous experience of sexual abuse (6; 7), the amount of sexual knowledge a client has (32) and the level of social isolation a client was experiencing (26). Participants were also mindful that a conversation might be more complex if a client was negatively affected by antipsychotic medication (14) or was older than them (34). There was general agreement that although other professionals may ask questions about intimate matters (60), a thorough risk assessment would most likely cover sexual and intimate matters (5).

A concurrent perspective demonstrated strong views on misconceptions about people with psychosis in terms of sexual and intimate relationship needs and the impact of mental health on behaviour. The highest possible disagreement was in terms of statements that sexuality was not important to people with psychosis (10). Participants widely recognised that sexual and intimate relationships may be part of someone's recovery journey (24). There was significant disagreement that people with psychosis that would neither be interested in a sexual relationship or would not ever experience an intimate relationship (11; 12; 13). In addition, there was strong disagreement around assumptions of the abilities of people with psychosis, specifically that they would not be able to maintain a relationship because of social or relationship skills (27; 46).

Statements reflecting possible behaviour in response to the experience of a psychotic illness were ranked in terms of strong disagreement. Participants did not feel that a conversation about sexuality and intimacy would result in disinhibited behaviour in an inpatient setting (56) or inappropriate behaviour towards others (50; 55), nor that asking about such a topic would influence a person's psychotic symptoms (64).

## Discussion

The aim of this Q-methodological study was to explore clinical psychologists' attitudes to talking about sexuality and intimacy with people with psychosis. Three accounts were identified that provide an insight into the different perspectives of clinical psychologists working with people with psychosis about addressing sexuality and intimacy with their clients.

### *The duty of clinical psychologists to address sexuality and intimacy*

As the dominant viewpoint, Factor A revealed a person-centred approach to talking about sex and intimacy with people with psychosis, and clinicians were comfortable addressing the topic in clinical settings. It is their duty to open conversations about it. Psychologists agreed that talking about sex and intimacy is a central aspect of humanity, and many commented that they would not avoid addressing it in their clinical work. Furthermore, they recognised the clinical benefits to talking about sex and intimacy, including the social support that can be accessed which acts as a buffer to potential relapse, and they were comfortable managing challenges in the clinical setting such as any distress or discomfort the client might experience.

This perspective highlights the importance of incorporating psychosocial factors and considering clients' broader social needs in psychological interventions with people with psychosis (Bertolote & McGorry, 2005). Clinical psychologists carefully assess and formulate the complex needs of clients with psychosis (Morberg Pain, Chadwick, & Abba, 2008), and interventions often include the integration of numerous psychological approaches, including cognitive-behavioural therapy (e.g. Fowler, Garety, & Kuipers, 1995; Nelson, 2005), family interventions (Bird et al., 2010) and recovery-focused approaches (May, 2004). Recovery models encourage clients to take responsibility for aspects of their own lives, including engaging in meaningful activities and seeking positive social opportunities (Davidson et al., 2007). The importance of social networks and meaningful relationships in the recovery process should not be underestimated, as the social support, sense of belonging and personal meaning may prevent relapse and buffer against future challenges (Soundy et al., 2015).



The ability to appropriately manage complex information is at the core of the clinical psychology and is in part what differentiates the profession from others (Division of Clinical Psychology, 2010). There is an expectation that qualified clinical psychologists should be proficient in skills and competencies to assess sensitive topics that other healthcare professionals may feel less confident in addressing. Competency frameworks suggest that at the point of graduation, newly qualified clinical psychologists should be able to draw upon a range of assessment, formulation and intervention measures to support clients individually and in couples (British Psychological Society, 2014a).

*Risk, contextual factors and the appropriateness of talking about sex and intimacy*

Factor B highlighted revealed a view amongst some clinical psychologists that conversations with people with psychosis about sexuality and intimacy might be biased more in favour of risk management and considering appropriateness than towards exploring intimate relationship needs of clients. This view indicated that psychological assessment and therapeutic intervention could proceed appropriately without the need to address sex and intimacy, and psychologists were mindful about whether clients would be comfortable with a clinical psychologist initiating a conversation that touched on intimate content. There appeared to be consideration of client-specific contextual factors, such as the level of social isolation a client experienced and their knowledge and understanding of sexual matters.

Some clinical psychologists appear to focus on management of risk and contextual issues rather than individual relationship needs and desires, and there are a range of factors which may account for this professional approach. In some clinical settings concerns that a client might pose a risk to themselves or others are the primary management issues for clinical psychologists (Division of Clinical Psychology, 2006b). This is particularly the case in clinical settings where client needs are complex and dependent on historical factors, such as psychiatric intensive care units and forensic wards (British Psychological Society, 2007; National Institute for Health and Care Excellence [NAPICU], 2014). The clinical psychologists in this factor may work in forensic settings, where risk to self and others is potentially higher than in

other clinical settings (e.g. Whitehead & Mason, 2006). In alternative explanation could be that the clinical psychologists contributing to this factor are more risk aware with people with psychosis because of previous experience of clients with sexual offences.

The literature on offending in individuals with psychosis provides a mixed and complex picture. Psychosis is sometimes associated with increased risk of violent conduct (Large, Smith, & Nielssen, 2009); however in general the rates of violent offending are low and may not be associated with psychiatric diagnosis (Maden, Scott, Burnett, Lewis, & Skapinakis, 2004). Multiple static and dynamic factors predict violent offending in individuals with psychosis, including history of substance abuse and previous violent behaviour (Witt, van Dorn, & Fazel, 2013) rather than simply a diagnosis itself (Douglas, Guy, & Hart, 2009).

#### *Clinical psychologists' competency and training in addressing sex and intimacy*

Factor C indicated that some clinical psychologists may be willing to discuss sexuality but feel limited by their skills. Whilst some clinical psychologists recognise that it is important that conversations do take place regarding sexuality and intimacy, concerns about potential repercussions of an insensitively approached discussion and concerns about competency limited clinical psychologists' willingness to open conversations.

The absence of a sense of their own competency in addressing sexuality and intimacy in this viewpoint may in part be explained by the lower level of experience participants had as qualified clinical psychologists. The clinical psychologists in this factor had five years less experience in practice than those in Factor A. It may be the case that these psychologists had not yet been presented with opportunities to engage in discussions with clients about sexuality and intimacy.

These findings reflect widespread perceptions that many healthcare professionals are reluctant to talk about sexuality in clinical practice. Studies have identified that avoidance of discussing sexuality with clients is linked to feared consequences, lack of organisational support and lack of training and resources (Dyer & das Nair, 2013).

Clinical psychology trainees have previously highlighted a gap in coverage of sexuality and sexual health teaching, resulting in them beginning their careers with less confidence and experience in dealing with sexual health matters (Shaw, Butler, & Marriott, 2008). Some clinical psychology training courses do not provide training in sexual therapy or around sexual dysfunction issues (Wiederman & Sansone, 1999). Where training does exist, it tends to focus on sexual violence or specific sexual disorders than on promoting sexual health (Miller & Byers, 2010).

### *Shared perspectives*

A shared perspective across participants demonstrated that clinical psychologists oppose views that sexuality is unimportant for people with psychosis and that they do not have the skills to maintain relationships. Public knowledge about severe and enduring mental health tends to vary depending on how it is examined (Pescosolido et al., 2010; Schomerus et al., 2012) which can result in discrimination and social exclusion for people suffering from psychosis (Rose et al., 2011). A further shared perspective reflected participants' agreement that it is the role of clinical psychologists to adapt to the nuances of their clinical work, such as considering personal characteristics and needs when engaging in discussions around sensitive topics. Clinical psychologists are well-placed to challenge misconceptions about psychosis and support their clients in dealing with the psychosocial consequences (British Psychological Society, 2014).

### *Implications for practice*

These findings highlight a need for improved provision of training around sexual health assessment in clinical psychology doctoral programmes. Frameworks exist to support training in sexual health for clinical psychology trainees (Division of Clinical Psychology, 2006a; Shaw, 2006), and many existing tools suggest appropriate questions and language to support practitioners to systematically assess clients' sexuality and intimacy needs (Butler, O'Donovan, & Shaw, 2010; Mick, Hughes, & Cohen, 2004)

Existing sexual health services for people with mental health difficulties are ill-equipped to meet the needs of the population of people suffering with psychosis. There is evidence that people with psychosis rate their sexual health and intimate relationship needs highly (Hensel et al., 2016) and are willing to talk to mental health professionals about sex and intimacy (McCann, 2010b; Southall, 2017). There is a need for specialist sexual health services to be commissioned for people with severe mental illness and sexual difficulties, staffed by professionals who are trained specifically to understand the many barriers that severe mental health difficulties present and the complexity of sexual issues.

### *Implications for future research*

This study highlights the need for a review of clinical psychology doctoral programmes in the United Kingdom. Considering that previous research in this area is now almost a decade old (Shaw, Butler, & Marriott, 2008), close examination of how training courses prepare trainee clinical psychologists for professional practice which might include sexual issues. In addition, future research may wish to explore whether attitudes to discussing sexuality and intimacy are affected by contextual or demographic factors, such as amount of time clinical psychologists have been qualified, the service setting psychologists work in or the length of time they have been working with clients with psychosis.

### *Study limitations*

The study methodology has some limitations. Most of the Q-sorts were collected using an online sorting tool to enable data collection from participants across the United Kingdom. Although sorting instructions were identical to the physical Q-sort procedure, and many of the supporting statements came from the web tool, the level of subjectivity may be somewhat reduced because of this method's usage. Many Q researchers argue that some of the subtle intricacies normally associated with Q-methodology can be lost when sorting is conducted remotely (Watts & Stenner, 2012; Brown, personal communication, January 6, 2017).

The Q-set did not comprehensively cover all issues clinical and professional that psychologists could experience, for example differentiating between perspectives from forensic services, inpatient settings and community services. A more focused approach to developing the statements might have enabled a Q-set that more accurately reflected the reality of working therapeutically with people with psychosis.

A further limitation was in the methodology selected for including Q-sorts in each factor. Automatic flagging was applied as more straightforward manual flagging only identified a small number of Q-sorts to be included in factors. Although this approach overcame a statistical issue with the analysis process, automatic pre-flagging is designed to only flag pure cases (Schmolck, 2014), and excludes the researcher's judgment on which cases are representative and should therefore be included in the analysis.

In addition, because the study failed to explore whether views and attitudes were affected by the clinical setting where participants worked, it is not possible to generalise the findings to different mental health settings, such as forensic settings.

### *Conclusion*

This study highlights the range of views of clinical psychologists working with people with psychosis within the NHS in terms of their role in engaging clients with psychosis about sexuality and intimacy. To the researcher's knowledge, this is the first empirical study that has explored clinical psychologist's attitudes around talking about sexual and intimate relationships with people with a severe mental health problem. Whilst all accounts recognised the importance of sexuality to people with psychosis, perspectives differed in terms of level of comfort with and perceived appropriateness of having conversations with clients in clinical settings.

The role of sexual and intimate relationships in wellbeing has previously been established (Baumeister & Leary, 1995), and it has recently been suggested that it is intimacy and affection, not sexual activity itself, that predicts life satisfaction (Debrot, Meuwly, Muise, Impett, & Schoebi, 2017). Sexual and intimate relationships are

important for all individuals, especially those with mental health difficulties whose relationship needs are often overlooked (Field et al., 2013; Patel, Flisher, Hetrick, & McGorry, 2007).

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## Appendices

### Appendix C University Ethical Approval



Faculty of Health Sciences

#### ETHICAL APPROVAL FEEDBACK

<b>Researcher name:</b>	Dan Southall
<b>Title of Study:</b>	A Q-sort study of clinical psychologist's attitudes to talking to service-users with psychosis about sex and intimacy
<b>Award Pathway:</b>	Prof Doc in Clinical Psychology
<b>Status of approval:</b>	Resubmitted version approved

Thank you for your revised application, and the covering letter.

Your revised application is approved. We wish you will with your research.

#### Action now needed:

Your application has now been approved by the Faculty's Ethics Panel.

You should note that any divergence from the approved procedures and research method will invalidate any insurance and liability cover from the University. You should, therefore, notify the Panel in writing of any significant divergence from this approved proposal.

You should arrange to meet with your supervisor for support during the process of completing your study and writing your dissertation.

When your study is complete, please send the ethics committee an end of study report. A template can be found on the ethics BlackBoard site

A handwritten signature in black ink that reads 'P M Kevern'.

**Signed:**  
Dr Peter Kevern  
Chair of the Faculty of Health Sciences Ethics Panel

**Date:** 19<sup>th</sup> January 2016





**Health Research Authority**

South Staffordshire and Shropshire Healthcare 

NHS Foundation Trust

*A Keele University Teaching Trust*

**From:** South Staffordshire and Shropshire Healthcare NHS Foundation Trust  
**To:** Dan Southall  
**Cc:** Dr Helen Combes  
**Subject:** Confirmation of Capacity and Capability at South Staffordshire and Shropshire Healthcare NHS Foundation Trust  
**Attachment:** Agreed statement of activities.  
**Date:** 7 October 2016

Dear Dan

**RE: IRAS Ref No 200997.**

**Full Study Title: Attitudes to talking to service-users with psychosis about sex**

This email confirms that **South Staffordshire and Shropshire Healthcare NHS Foundation Trust** has the capacity and capability to deliver the above referenced study. Please find attached our agreed Statement of Activities as confirmation.

We agree to start this study on **10 October 2016**, If you wish to discuss further, please do not hesitate to contact me.

Kind regards

Ruth Lambley Burke,  
Head of Research and Innovation  
Block 7, St George's Hospital, Corporation Street, Stafford ST16 3AG

## Appendix E Participant information sheet

IRAS ID: 200997  
Version 2: 28/6/2016



### STAFFORDSHIRE AND KEELE DOCTORATE IN CLINICAL PSYCHOLOGY - INFORMATION SHEET FOR RESEARCH PARTICIPATION - Q-SORT

#### PROJECT TITLE: A Q-SORT STUDY OF CLINICAL PSYCHOLOGISTS' VIEWS OF DISCUSSING ISSUES OF SEX AND INTIMACY WITH SERVICE USERS

##### **Project aims:**

This research project aims to explore the views of clinical psychologists about how issues of sexuality and intimate relationships are discussed and addressed with service-users. You have been asked to participate in this study because you are a psychologist that works with this clinical population.

##### **What the study will involve:**

The study will involve reading a number of statements about sexuality, intimacy and psychosis and ranking them in terms of your agreement or disagreement with each statement. The study should take no longer than 1 – 1.5 hours.

##### **Background to the study:**

The British Psychological Society, NICE and The Schizophrenia Commission all highlight the need to promote recovery, social support and independence in their policy guidelines. One area of need highlighted by service-users with psychosis and their families is around sexual expression and intimate relationships. However, although research suggests that service-users would like to discuss sex and intimacy, it is an area often avoided by mental health professionals for a number of reasons.

Clinical psychology is at the forefront of developing frameworks to lead research and provide support, assessment, and intervention in psychosis, but the role of clinical psychologists in addressing issues of sexuality and intimate relationships is unclear. This study aims to explore the attitudes of clinical psychologists in discussing this sensitive area with service users.

##### **Do I have to participate?**

It is entirely your decision to take part in the study. If you agree to participate, you will be asked to participate in the activities as described above. You are free to withdraw at any point during participation and for one month afterwards, at which point data analysis will commence. After this point, it will no longer be possible to retroactively extract your data from the study. Please speak to the researcher if you require clarification.

##### **What are the possible disadvantages and risks of taking part?**

Sexual expression and intimacy is a sensitive topic, so there is a small risk that participation may at times be embarrassing. However, you are being asked for your views on discussing sexual on a professional level and not on a personal level.

##### **What are the benefits of taking part?**

There are a number of benefits to taking part: firstly, because this subject area is significantly under-researched, it is hoped that any resulting publication will generate further interest and debate. Furthermore, it is hoped that participants will find participation interesting and stimulating. It should be pointed out also that the aim of the study is not to highlight missing areas of clinical practice; it is to highlight areas for further

## Appendix F Participant consent form

IRAS ID: 200997  
Version 2: 28/6/2016



Centre number:

Study number:

Participant identification number for this study:

### CONSENT FORM

PROJECT TITLE: A Q-SORT STUDY OF CLINICAL PSYCHOLOGIST'S VIEWS OF DISCUSSING ISSUES OF SEX AND INTIMACY WITH SERVICE USERS

I confirm that I have read and understood the information sheet for the above study. I have had the opportunity to consider the information and ask relevant questions, which have been answered satisfactorily.

(Please tick to confirm your agreement)

I understand that I have the right to withdraw from participation at any time during the study process and I can request withdrawal of my data for a period of one month after I participate.

(Please tick to confirm your agreement)

I understand that any information I provide is confidential, and that no information provided will be subject to identification of participants by third parties. I understand that the primary researcher will hold all information provided in a secure location.

(Please tick to confirm your agreement)

I understand that I have the right to ask questions relating to the research or my participation in the study at any time before or my participation.

(Please tick to confirm your agreement)

I understand that the final written submission of this project may include comments or quotes I have provided in relation to participation in this research. I give my permission for these to be included in the final piece, and I understand that this piece of research may also be submitted to an academic journal for publication.

(Please tick to confirm your agreement)

Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Consent forms: One copy should be kept for filing purposes and one copy should be retained by the participant.

Appendix G  
Post-sort interview

PROJECT TITLE: A Q-SORT STUDY OF CLINICAL PSYCHOLOGIST'S VIEWS OF DISCUSSING ISSUES OF  
SEX AND INTIMACY WITH SERVICE USERS

Post Study Questionnaire

Your participant ID number (First three letters of your mother's maiden name and three digits of your birthday):

Are there any topical areas, issues or statements that you feel have **NOT** been included in the Q-sort?

What statements would **YOU** have included?

What ranking would you have given this statement(s)?

Has the issue of sexuality and intimate relationships for people with psychosis occurred to you before?

Have you ever reflected on the lack of opportunities to engage in intimate relationships for people with psychosis?

Have clients stated to you that they would like to access intimate relationships?

Are there any statements that did not make sense?

Are there specific reasons that you have assigned certain rankings to statements, for example, more extreme values (-6 or +6)?

Do you have any further reflections on the Q-sort now that you have completed the study?

**Many thanks again for taking part!**

**Daniel Southall**

## Appendix H

Exemplar Q-sort for Factor A: The sexual and relationship needs of people with psychosis are the same as everyone else's, and it is our duty to talk about them.

Most disagree												Most agree
-6	-5	-4	-3	-2	-1	0	1	2	3	4	5	6
10. It is not important for people with psychosis to have sexual relationships	9. I would not talk to people experiencing psychosis about sex and intimate relationships as they don't have any experiences of these things	27. I would not talk about sex and intimacy because I would assume that people do not have the social skills to maintain a relationship	41. I would worry that someone's sexual issues would be too complex for me to talk about with them	34. I would be cautious about talking with someone who was older than me about sex and intimacy	2. I would prioritise other issues in therapy that might not include sex and intimacy	65. I would feel uncomfortable talking about sex and intimacy if it significantly increased the risk of someone subsequently placing themselves in a vulnerable situation	48. I would feel disappointed if someone did not raise issues of sex and intimacy with me if it was important to them	61. I would feel comfortable talking about sex and intimacy, as this might be a sign of growing trust and good progress in psychological therapy	30. I would be mindful of the emotional pain of talking about sex and intimacy	47. I would talk about sex and intimacy because I would feel that it is perfectly normal to speak about it in therapy	38. It is important to talk about sex and intimacy as it can be a normalising experience	3. I would consider discussing issues of sex and intimacy just as appropriate with clients with psychosis as I would with clients with any presentation
11. People with psychosis will never have sex	12. It would be unkind to talk to people about things that are never going to happen for them	40. I do not have training to talk to people about sex	42. I would not feel comfortable talking about sex and intimacy	44. Raising issues of sex and intimacy would be embarrassing for me	25. Cognitive impairment might negatively affect the ability to engage in a discussion about sex and intimacy	63. I would feel uncomfortable talking about sex and intimacy if the acts of thinking and talking about these subjects might be too distressing for someone to manage	29. I would be mindful that people might feel too ashamed or embarrassed to talk about sex and intimacy	60. I would feel comfortable talking about sex and intimacy because peoples' needs in these areas are often overlooked or ignored by clinicians and helpers	18. Asking about sex and intimacy can help some people feel more open to talking about their difficulties	39. Talking to people about sex and intimate relationships can provide them with the opportunity to talk about other sensitive areas of their lives that impact on their difficulties	17. It is important not to make assumptions about a person's experiences and attitudes towards sex	21. Talking about sex and intimacy is important as it is a major factor in many people's lives
13. People with psychosis are not interested in developing intimate or sexual relationships	46. I would not talk to people with psychosis about sex and intimacy because I would not expect them to be a good partner	54. I would not talk about sex and intimacy as someone may become aroused by it	50. I would not talk about sex and intimacy as someone may become disinhibited	45. I would worry that I would offend someone if I raised sex and intimacy with them in a session	33. I would be cautious about talking with someone of the opposite gender about sex and intimacy	53. I don't think raising issues of sex and intimacy would negatively affect a person's mental health	28. I would be mindful of how uncomfortable and awkward it might be for someone to talk about sex and intimacy	37. I would find it hard not to talk about sex and intimacy, as it is often integral to the development of someone's difficulties	14. Sexual difficulties caused by anti-psychotic medication might affect the ability to have sexual relationships	35. I like to let people know it is ok to talk about sex and intimacy	24. A discussion about sex and intimacy might be an important part of someone's recovery process	59. I would feel comfortable discussing sex and intimacy because these topics are part of what it means to be human
	43. I would not feel competent to talk about sex and intimacy	55. I would not talk about sex and intimacy as people can be unpredictable and scary and they may act on our conversations with non-consenting others	57. I would worry that talking about sex and intimacy might encourage someone to engage in unsafe sex	51. I would not talk to people about sex and intimacy as they may become confused about boundaries	49. Talking about sex and intimacy may not be appropriate if someone is currently unstable	32. I like to let people know that it is OK for them to have gaps in their knowledge about sex and intimacy	20. I would talk to about sex and intimacy as part of developing a trusting therapeutic relationship	23. Talking about sex and intimacy is important because the social support people can access may help them prevent relapse	15. People should be able to talk to professionals about sex and intimacy	36. I would have to talk about sex and intimacy in order to have a robust and holistic understanding of someone	4. Any thorough assessment should cover intimate relationships	
			58. I would worry that talking about sex and intimacy might result in an unwanted pregnancy occurring	62. I would feel uncomfortable talking about sex and intimacy if I had reason to believe that someone might misinterpret such a discussion as a sign of my own sexual interest in them	56. I would not talk about sex and intimacy because it might affect someone's behaviour in a ward environment	31. I would be mindful that people might struggle to be honest about how much they know about sex and intimate relationships	6. I would ask questions about sex and intimacy if I suspected a person was vulnerable to abuse	22. Talking about sex and intimacy is important because it may help someone access much-needed social support	5. Asking about sex and intimacy may be necessary as part of a risk assessment			

64. I would feel uncomfortable talking about sex and intimacy because it may add to a person's persecutory beliefs	66. I would feel uncomfortable talking about sex and intimacy if it significantly increased the risk of someone subsequently harming themselves or someone else	26. I would be mindful that a person might be too socially isolated to have intimate relationships	7. I would ask questions about sex and intimacy if I was aware that someone had experienced previous abuse or sexual trauma	19. I would talk about sex and intimacy because there may be no one else who will
	52. I would not talk about sex and intimacy if I felt it may increase someone's distress	16. It is important to respect that some people do not want to talk about sex and intimacy	1. I would talk about it sex and intimacy if I felt it were relevant and clinically appropriate	
		8. I would talk about sex and intimacy if someone was already in an intimate relationship		

## Appendix I

Exemplar Q-sort for Factor B: I would talk to people with psychosis about sex and intimacy, being mindful of the possible risks and concerns.

<b>Most disagree</b>											<b>Most agree</b>	
<b>-6</b>	<b>-5</b>	<b>-4</b>	<b>-3</b>	<b>-2</b>	<b>-1</b>	<b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>	<b>6</b>
10. It is not important for people with psychosis to have sexual relationships	58. I would worry that talking about sex and intimacy might result in an unwanted pregnancy occurring	12. It would be unkind to talk to people about things that are never going to happen for them	34. I would be cautious about talking with someone who was older than me about sex and intimacy	37. I would find it hard not to talk about sex and intimacy, as it is often integral to the development of someone's difficulties	8. I would talk about sex and intimacy if someone was already in an intimate relationship	2. I would prioritise other issues in therapy that might not include sex and intimacy	7. I would ask questions about sex and intimacy if I was aware that someone had experienced previous abuse or sexual trauma	3. I would consider discussing issues of sex and intimacy just as appropriate with clients with psychosis as I would with clients with any presentation	18. Asking about sex and intimacy can help some people feel more open to talking about their difficulties	5. Asking about sex and intimacy may be necessary as part of a risk assessment	16. It is important to respect that some people do not want to talk about sex and intimacy	1. I would talk about it sex and intimacy if I felt it were relevant and clinically appropriate
11. People with psychosis will never have sex	46. I would not talk to people with psychosis about sex and intimacy because I would not expect them to be a good partner	55. I would not talk about sex and intimacy as people can be unpredictable and scary and they may act on our conversations with non-consenting others	36. I would have to talk about sex and intimacy in order to have a robust and holistic understanding of someone	41. I would worry that someone's sexual issues would be too complex for me to talk about with them	19. I would talk about sex and intimacy because there may be no-one else who will	4. Any thorough assessment should cover intimate relationships	21. Talking about sex and intimacy is important as it is a major factor in many people's lives	6. I would ask questions about sex and intimacy if I suspected a person was vulnerable to abuse	31. I would be mindful that people might struggle to be honest about how much they know about sex and intimate relationships	15. People should be able to talk to professionals about sex and intimacy	24. A discussion about sex and intimacy might be an important part of someone's recovery process	17. It is important not to make assumptions about a person's experiences and attitudes towards sex
13. People with psychosis are not interested in developing intimate or sexual relationships	27. I would not talk about sex and intimacy because I would assume that people do not have the social skills to maintain a relationship	56. I would not talk about sex and intimacy because it might affect someone's behaviour in a ward environment	43. I would not feel competent to talk about sex and intimacy	42. I would not feel comfortable talking about sex and intimacy	33. I would be cautious about talking with someone of the opposite gender about sex and intimacy	23. Talking about sex and intimacy is important because the social support people can access may help them prevent relapse	22. Talking about sex and intimacy is important because it may help someone access much-needed social support	14. Sexual difficulties caused by anti-psychotic medication might affect the ability to have sexual relationships	39. Talking to people about sex and intimate relationships can provide them with the opportunity to talk about other sensitive areas of their lives that impact on their difficulties	62. I would feel uncomfortable talking about sex and intimacy if I had reason to believe that someone might misinterpret such a discussion as a sign of my own sexual interest in them	30. I would be mindful of the emotional pain of talking about sex and intimacy	29. I would be mindful that people might feel too ashamed or embarrassed to talk about sex and intimacy
	9. I would not talk to people experiencing psychosis about sex and intimate relationships as they don't have any experiences of these things	57. I would worry that talking about sex and intimacy might encourage someone to engage in unsafe sex	45. I would worry that I would offend someone if I raised sex and intimacy with them in a session	44. Raising issues of sex and intimacy would be embarrassing for me	40. I do not have training to talk to people about sex	25. Cognitive impairment might negatively affect the ability to engage in a discussion about sex and intimacy	26. I would be mindful that a person might be too socially isolated to have intimate relationships	32. I like to let people know that it is OK for them to have gaps in their knowledge about sex and intimacy	63. I would feel uncomfortable talking about sex and intimacy if the acts of thinking and talking about these subjects might be too distressing for someone to manage	66. I would feel uncomfortable talking about sex and intimacy if it significantly increased the risk of someone subsequently harming themselves or someone else	28. I would be mindful of how uncomfortable and awkward it might be for someone to talk about sex and intimacy	
			50. I would not talk about sex and intimacy as someone may become disinhibited	64. I would feel uncomfortable talking about sex and intimacy because it may add to a person's persecutory beliefs	53. I don't think raising issues of sex and intimacy would negatively affect a person's mental health	35. I like to let people know it is ok to talk about sex and intimacy	38. It is important to talk about sex and intimacy as it can be a normalising experience	52. I would not talk about sex and intimacy if I felt it may increase someone's distress	65. I would feel uncomfortable talking about sex and intimacy if it significantly increased the risk of someone subsequently placing themselves in a vulnerable situation			



20. I would talk to about sex and intimacy as part of developing a trusting therapeutic relationship	54. I would not talk about sex and intimacy as someone may become aroused by it	47. I would talk about sex and intimacy because I would feel that it is perfectly normal to speak about it in therapy	49. Talking about sex and intimacy may not be appropriate if someone is currently unstable	59. I would feel comfortable discussing sex and intimacy because these topics are part of what it means to be human
	51. I would not talk to people about sex and intimacy as they may become confused about boundaries	48. I would feel disappointed if someone did not raise issues of sex and intimacy with me if it was important to them	60. I would feel comfortable talking about sex and intimacy because peoples' needs in these areas are often overlooked or ignored by clinicians and helpers	
		61. I would feel comfortable talking about sex and intimacy, as this might be a sign of growing trust and good progress in psychological therapy		

## Appendix J

### Exemplar Q-sort for Factor C: People with psychosis should be able to talk about sex and intimacy, but perhaps not with me

**Most disagree**

**Most agree**

-6	-5	-4	-3	-2	-1	0	+1	+2	+3	+4	+5	+6
9. I would not talk to people experiencing psychosis about sex and intimate relationships as they don't have any experiences of these things	12. It would be unkind to talk to people about things that are never going to happen for them	27. I would not talk about sex and intimacy because I would assume that people do not have the social skills to maintain a relationship	25. Cognitive impairment might negatively affect the ability to engage in a discussion about sex and intimacy	34. I would be cautious about talking with someone who was older than me about sex and intimacy	18. Asking about sex and intimacy can help some people feel more open to talking about their difficulties	21. Talking about sex and intimacy is important as it is a major factor in many people's lives	4. Any thorough assessment should cover intimate relationships	5. Asking about sex and intimacy may be necessary as part of a risk assessment	1. I would talk about it sex and intimacy if I felt it were relevant and clinically appropriate	14. Sexual difficulties caused by anti-psychotic medication might affect the ability to have sexual relationships	3. I would consider discussing issues of sex and intimacy just as appropriate with clients with psychosis as I would with clients with any presentation	15. People should be able to talk to professionals about sex and intimacy
10. It is not important for people with psychosis to have sexual relationships	13. People with psychosis are not interested in developing intimate or sexual relationships	46. I would not talk to people with psychosis about sex and intimacy because I would not expect them to be a good partner	50. I would not talk about sex and intimacy as someone may become disinhibited	35. I like to let people know it is ok to talk about sex and intimacy	20. I would talk to about sex and intimacy as part of developing a trusting therapeutic relationship	22. Talking about sex and intimacy is important because it may help someone access much-needed social support	32. I like to let people know that it is OK for them to have gaps in their knowledge about sex and intimacy	7. I would ask questions about sex and intimacy if I was aware that someone had experienced previous abuse or sexual trauma	2. I would prioritise other issues in therapy that might not include sex and intimacy	24. A discussion about sex and intimacy might be an important part of someone's recovery process	28. I would be mindful of how uncomfortable and awkward it might be for someone to talk about sex and intimacy	40. I do not have training to talk to people about sex
11. People with psychosis will never have sex	57. I would worry that talking about sex and intimacy might encourage someone to engage in unsafe sex	54. I would not talk about sex and intimacy as someone may become aroused by it	51. I would not talk to people about sex and intimacy as they may become confused about boundaries	37. I would find it hard not to talk about sex and intimacy, as it is often integral to the development of someone's difficulties	33. I would be cautious about talking with someone of the opposite gender about sex and intimacy	23. Talking about sex and intimacy is important because the social support people can access may help them prevent relapse	38. It is important to talk about sex and intimacy as it can be a normalising experience	30. I would be mindful of the emotional pain of talking about sex and intimacy	6. I would ask questions about sex and intimacy if I suspected a person was vulnerable to abuse	53. I don't think raising issues of sex and intimacy would negatively affect a person's mental health	29. I would be mindful that people might feel too ashamed or embarrassed to talk about sex and intimacy	41. I would worry that someone's sexual issues would be too complex for me to talk about with them
	58. I would worry that talking about sex and intimacy might result in an unwanted pregnancy occurring	55. I would not talk about sex and intimacy as people can be unpredictable and scary and they may act on our conversations with non-consenting others	56. I would not talk about sex and intimacy because it might affect someone's behaviour in a ward environment		42. I would not feel comfortable talking about sex and intimacy	44. Raising issues of sex and intimacy would be embarrassing for me	26. I would be mindful that a person might be too socially isolated to have intimate relationships	43. I would not feel competent to talk about sex and intimacy	16. It is important to respect that some people do not want to talk about sex and intimacy	63. I would feel uncomfortable talking about sex and intimacy if the acts of thinking and talking about these subjects might be too distressing for someone to manage	17. It is important not to make assumptions about a person's experiences and attitudes towards sex	
			64. I would feel uncomfortable talking about sex and intimacy because it may add to a person's persecutory beliefs	47. I would talk about sex and intimacy because I would feel that it is perfectly normal to speak about it in therapy	49. Talking about sex and intimacy may not be appropriate if someone is currently unstable	31. I would be mindful that people might struggle to be honest about how much they know about sex and intimate relationships	52. I would not talk about sex and intimacy if I felt it may increase someone's distress	48. I would feel disappointed if someone did not raise issues of sex and intimacy with me if it was important to them	19. I would talk about sex and intimacy because there may be no-one else who will			
				8. I would talk about sex and intimacy if someone was already in an intimate relationship	59. I would feel comfortable discussing sex and intimacy because these topics are part of what it means to be human	36. I would have to talk about sex and intimacy in order to have a robust and holistic understanding of someone	60. I would feel comfortable talking about sex and intimacy because peoples' needs in these areas are often overlooked or ignored by clinicians and helpers	66. I would feel uncomfortable talking about sex and intimacy if it significantly increased the risk of someone subsequently harming themselves or someone else				

<p>61. I would feel comfortable talking about sex and intimacy, as this might be a sign of growing trust and good progress in psychological therapy</p>	<p>45. I would worry that I would offend someone if I raised sex and intimacy with them in a session</p>	<p>65. I would feel uncomfortable talking about sex and intimacy if it significantly increased the risk of someone subsequently placing themselves in a vulnerable situation</p>
	<p>62. I would feel uncomfortable talking about sex and intimacy if I had reason to believe that someone might misinterpret such a discussion as a sign of my own sexual interest in them</p>	

### Factor 1 crib sheet

**\* denotes significance at  $p < .05$**

**\*\* denotes significance at  $p < .01$**

**Highlighted text denotes consensus statement at  $p < .01$**

#### **Which items ranked at +6**

3. I would consider discussing issues of sex and intimacy just as appropriate with clients with psychosis as I would with clients with any presentation

21. Talking about sex and intimacy is important as it is a major factor in many people's lives \*\*

59. I would feel comfortable discussing sex and intimacy because these topics are part of what it means to be human \*\*

#### **Which items ranked at +5**

4. Any thorough assessment should cover intimate relationships \*\*

17. It is important not to make assumptions about a person's experiences and attitudes towards sex

24. A discussion about sex and intimacy might be an important part of someone's recovery process

38. It is important to talk about sex and intimacy as it can be a normalising experience \*\*

#### **Which items ranked higher than other factors?**

8. I would talk about sex and intimacy if someone was already in an intimate relationship<sub>(0)</sub> \*\*

20. I would talk to about sex and intimacy as part of developing a trusting therapeutic relationship (+1) \*\*

22. Talking about sex and intimacy is important because it may help someone access much-needed social support (+2)

23. Talking about sex and intimacy is important because the social support people can access may help them prevent relapse (+2)

35. I like to let people know it is ok to talk about sex and intimacy (+4) \*\*

36. I would have to talk about sex and intimacy in order to have a robust and holistic understanding of someone (+4) \*\*

37. I would find it hard not to talk about sex and intimacy, as it is often integral to the development of someone's difficulties (+2) \*\*

39. Talking to people about sex and intimate relationships can provide them with the opportunity to talk about other sensitive areas of their lives that impact on their difficulties (+4)

47. I would talk about sex and intimacy because I would feel that it is perfectly normal to speak about it in therapy (+4) \*\*

56. I would not talk about sex and intimacy because it might affect someone's behaviour in a ward environment (-1)

58. I would worry that talking about sex and intimacy might result in an unwanted pregnancy occurring (-3) \*

60. I would feel comfortable talking about sex and intimacy because peoples' needs in these areas are often overlooked or ignored by clinicians and helpers (+2)

61. I would feel comfortable talking about sex and intimacy, as this might be a sign of growing trust and good progress in psychological therapy (+2+) \*\*

### **Which items ranked at -6**

10. It is not important for people with psychosis to have sexual relationships

11. People with psychosis will never have sex

13. People with psychosis are not interested in developing intimate or sexual relationships

### **Which items ranked at -5**

9. I would not talk to people experiencing psychosis about sex and intimate relationships as they don't have any experiences of these things

12. It would be unkind to talk to people about things that are never going to happen for them

43. I would not feel competent to talk about sex and intimacy \*

46. I would not talk to people with psychosis about sex and intimacy because I would not expect them to be a good partner

### **Which items ranked lower than other factors?**

2. I would prioritise other issues in therapy that might not include sex and intimacy (-1)

6. I would ask questions about sex and intimacy if I suspected a person was vulnerable to abuse (+1)

16. It is important to respect that some people do not want to talk about sex and intimacy (0)

28. I would be mindful of how uncomfortable and awkward it might be for someone to talk about sex and intimacy (+1) \*

29. I would be mindful that people might feel too ashamed or embarrassed to talk about sex and intimacy (+1) \*

32. I like to let people know that it is OK for them to have gaps in their knowledge about sex and intimacy (0)

40. I do not have training to talk to people about sex (-4) \*\*

41. I would worry that someone's sexual issues would be too complex for me to talk about with them (-3) \*

42. I would not feel comfortable talking about sex and intimacy (-3)

52. I would not talk about sex and intimacy if I felt it may increase someone's distress (-1)

63. I would feel uncomfortable talking about sex and intimacy if the acts of thinking and talking about these subjects might be too distressing for someone to manage (0) \*\*

65. I would feel uncomfortable talking about sex and intimacy if it significantly increased the risk of someone subsequently placing themselves in a vulnerable situation (0)

66. I would feel uncomfortable talking about sex and intimacy if it significantly increased the risk of someone subsequently harming themselves or someone else (-1) \*

## Factor 2 crib sheet

\* denotes significance at  $p < .05$

\*\* denotes significance at  $p < .01$

Highlighted text denotes consensus statement at  $p < .01$

### Which items ranked at +6

1. I would talk about it sex and intimacy if I felt it were relevant and clinically appropriate

17. It is important not to make assumptions about a person's experiences and attitudes towards sex

29. I would be mindful that people might feel too ashamed or embarrassed to talk about sex and intimacy

### Which items ranked at +5

16. It is important to respect that some people do not want to talk about sex and intimacy

24. A discussion about sex and intimacy might be an important part of someone's recovery process

28. I would be mindful of how uncomfortable and awkward it might be for someone to talk about sex and intimacy

30. I would be mindful of the emotional pain of talking about sex and intimacy

### Which items ranked higher than other factors?

5. Asking about sex and intimacy may be necessary as part of a risk assessment (+4)

12. It would be unkind to talk to people about things that are never going to happen for them (-4)

26. I would be mindful that a person might be too socially isolated to have intimate relationships (+1)

31. I would be mindful that people might struggle to be honest about how much they know about sex and intimate relationships (+3) \*

32. I like to let people know that it is OK for them to have gaps in their knowledge about sex and intimacy (+2)

49. Talking about sex and intimacy may not be appropriate if someone is currently unstable\* (+1)

51. I would not talk to people about sex and intimacy as they may become confused about boundaries (-1) \*

52. I would not talk about sex and intimacy if I felt it may increase someone's distress (+2)

62. I would feel uncomfortable talking about sex and intimacy if I had reason to believe that someone might misinterpret such a discussion as a sign of my own sexual interest in them (+4) \*\*

65. I would feel uncomfortable talking about sex and intimacy if it significantly increased the risk of someone subsequently placing themselves in a vulnerable situation (+3)

66. I would feel uncomfortable talking about sex and intimacy if it significantly increased the risk of someone subsequently harming themselves or someone else (+4)

### **Which items ranked at -6**

10. It is not important for people with psychosis to have sexual relationships

11. People with psychosis will never have sex

13. People with psychosis are not interested in developing intimate or sexual relationships

### **Which items ranked at -5**

9. I would not talk to people experiencing psychosis about sex and intimate relationships as they don't have any experiences of these things

27. I would not talk about sex and intimacy because I would assume that people do not have the social skills to maintain a relationship

46. I would not talk to people with psychosis about sex and intimacy because I would not expect them to be a good partner

58. I would worry that talking about sex and intimacy might result in an unwanted pregnancy occurring



### **Which items ranked lower than other factors?**

2. I would prioritise other issues in therapy that might not include sex and intimacy (0)

3. I would consider discussing issues of sex and intimacy just as appropriate with clients with psychosis as I would with clients with any presentation (2)

34. I would be cautious about talking with someone who was older than me about sex and intimacy (-3)

36. I would have to talk about sex and intimacy in order to have a robust and holistic understanding of someone (-3) \*

45. I would worry that I would offend someone if I raised sex and intimacy with them in a session (-3)

48. I would feel disappointed if someone did not raise issues of sex and intimacy with me if it was important to them (0) \*

53. I don't think raising issues of sex and intimacy would negatively affect a person's mental health (-1)

56. I would not talk about sex and intimacy because it might affect someone's behaviour in a ward environment (-4)

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### **Factor 3 crib sheet**

\* denotes significance at  $p < .05$

\*\* denotes significance at  $p < .01$

Highlighted text denotes consensus statement at  $p < .01$

### **Which items ranked at +6**

15. People should be able to talk to professionals about sex and intimacy \*

40. I do not have training to talk to people about sex \*\*

41. I would worry that someone's sexual issues would be too complex for me to talk about with them \*\*

### **Which items ranked at +5**

3. I would consider discussing issues of sex and intimacy just as appropriate with clients with psychosis as I would with clients with any presentation

17. It is important not to make assumptions about a person's experiences and attitudes towards sex

28. I would be mindful of how uncomfortable and awkward it might be for someone to talk about sex and intimacy

29. I would be mindful that people might feel too ashamed or embarrassed to talk about sex and intimacy

### **Which items ranked higher than other factors?**

2. I would prioritise other issues in therapy that might not include sex and intimacy (+3) \*\*

6. I would ask questions about sex and intimacy if I suspected a person was vulnerable to abuse (+3)

7. I would ask questions about sex and intimacy if I was aware that someone had experienced previous abuse or sexual trauma (+2)

14. Sexual difficulties caused by anti-psychotic medication might affect the ability to have sexual relationships (+4)

19. I would talk about sex and intimacy because there may be no-one else who will (+3)

43. I would not feel competent to talk about sex and intimacy (+2) \*\*

44. Raising issues of sex and intimacy would be embarrassing for me (-1)

45. I would worry that I would offend someone if I raised sex and intimacy with them in a session (0) \*

46. I would not talk to people with psychosis about sex and intimacy because I would not expect them to be a good partner (-4)

48. I would feel disappointed if someone did not raise issues of sex and intimacy with me if it was important to them (+2)

53. I don't think raising issues of sex and intimacy would negatively affect a person's mental health (+4) \*\*

### **Which items ranked at -6**

9. I would not talk to people experiencing psychosis about sex and intimate relationships as they don't have any experiences of these things

10. It is not important for people with psychosis to have sexual relationships

11. People with psychosis will never have sex

### **Which items ranked at -5**

12. It would be unkind to talk to people about things that are never going to happen for them

13. People with psychosis are not interested in developing intimate or sexual relationships

57. I would worry that talking about sex and intimacy might encourage someone to engage in unsafe sex

58. I would worry that talking about sex and intimacy might result in an unwanted pregnancy occurring

### **Which items ranked lower than other factors?**

5. Asking about sex and intimacy may be necessary as part of a risk assessment (+2)

8. I would talk about sex and intimacy if someone was already in an intimate relationship (-3)

18. Asking about sex and intimacy can help some people feel more open to talking about their difficulties (-1) \*\*

21. Talking about sex and intimacy is important as it is a major factor in many people's lives (0)

22. Talking about sex and intimacy is important because it may help someone access much-needed social support (0)

23. Talking about sex and intimacy is important because the social support people can access may help them prevent relapse (0)

25. Cognitive impairment might negatively affect the ability to engage in a discussion about sex and intimacy (-3)

30. I would be mindful of the emotional pain of talking about sex and intimacy (+2)

35. I like to let people know it is ok to talk about sex and intimacy (-2)

39. Talking to people about sex and intimate relationships can provide them with the opportunity to talk about other sensitive areas of their lives that impact on their difficulties (+1)

47. I would talk about sex and intimacy because I would feel that it is perfectly normal to speak about it in therapy (-2)

51. I would not talk to people about sex and intimacy as they may become confused about boundaries (-3)

59. I would feel comfortable discussing sex and intimacy because these topics are part of what it means to be human (-1) \*\*

61. I would feel comfortable talking about sex and intimacy, as this might be a sign of growing trust and good progress in psychological therapy (-1)

64. I would feel uncomfortable talking about sex and intimacy because it may add to a person's persecutory beliefs (-3)

Appendix L

Recruitment notice published in *The Psychologist* magazine

**I am recruiting participants for a research project as part of my professional doctorate in clinical psychology at Staffordshire University. The study uses a Q-sort methodology to explore clinical psychologists' views and attitudes in discussing issues of sexuality and intimacy with clients with psychosis.**

**I wish to recruit clinical psychologists engaged in regular clinical work with individuals with psychosis in both inpatient and community settings. The study can be completed online and should take no longer than 30 – 45 mins. Data will be stored confidentially and participants will not be identifiable.**

**To take part or to find out more, please contact Dan Southall**  
[Daniel.southall@nhs.net](mailto:Daniel.southall@nhs.net)

Appendix M  
Participant recruitment email.

Dear all,

I am recruiting participants for my Q-sort study exploring clinical psychologists' views about discussing sex and intimacy with people with psychosis. I would like to recruit clinical psychologists who work with people with psychosis to take part in the online version of the Qsort, which takes about 45 minutes to complete.

The link is <http://southall.poetq.com/ds200997>. The system allows to you read all the study information, provide your written consent and provide some details about how you completed the Q-sort at the end.

Attached is a post sort questionnaire, please take the time afterwards to let me have some comments on the Q-sort, any thoughts you have about the subject and anything else I need to know. You can email the questionnaire straight back to me. John Sorenson is aware that I am emailing to recruit participants. I have also attached my letter of access to confirm ethical approval.

I hope you enjoy it! Very grateful for your participation.

Best wishes,

Dan

Dan Southall  
Trainee Clinical Psychologist  
[daniel.southall@nhs.net](mailto:daniel.southall@nhs.net)

**Please rank the following statements based on what you think and how you feel as a clinical psychologist about *discussing issues of sex and intimacy with people with psychosis.***

When you are ranking the statements, remember that the statements are about your views as a clinical psychologist, and that terms such as ***‘people’***, ***‘the person’*** and ***‘someone’*** refers to individuals with psychosis who you may see as part of clinical work. The term ***sex and intimacy*** refers to **intimate, close and romantic relationships** in general, and not just sex and sexual relationships.

Some statements may refer broadly to sexuality and intimacy issues that would influence your views on discussing sex and intimacy with people with psychosis.

Appendix O  
Factor arrays

No.	Statement	Factor Arrays		
		F1	F2	F3
1	I would talk about it sex and intimacy if I felt it were relevant and clinically appropriate	1	6	3
2	I would prioritise other issues in therapy that might not include sex and intimacy	-1	0	3
3	I would consider discussing issues of sex and intimacy just as appropriate with clients with psychosis as I would with clients with any presentation	6	2	5
4	Any thorough assessment should cover intimate relationships	5	0	1
5	Asking about sex and intimacy may be necessary as part of a risk assessment	3	4	2
6	I would ask questions about sex and intimacy if I suspected a person was vulnerable to abuse	1	2	3
7	I would ask questions about sex and intimacy if I was aware that someone had experienced previous abuse or sexual trauma	1	1	2
8	I would talk about sex and intimacy if someone was already in an intimate relationship	0	-1	-3
9	I would not talk to people experiencing psychosis about sex and intimate relationships as they don't have any experiences of these things	-5	-5	-6
10	It is not important for people with psychosis to have sexual relationships	-6	-6	-6
11	People with psychosis will never have sex	-6	-6	-6
12	It would be unkind to talk to people about things that are never going to happen for them	-5	-4	-5
13	People with psychosis are not interested in developing intimate or sexual relationships	-6	-6	-5
14	Sexual difficulties caused by anti-psychotic medication might affect the ability to have sexual relationships	3	2	4
15	People should be able to talk to professionals about sex and intimacy	3	4	6
16	It is important to respect that some people do not want to talk about sex and intimacy	0	5	3
17	It is important not to make assumptions about a person's experiences and attitudes towards sex	5	6	5
18	Asking about sex and intimacy can help some people feel more open to talking about their difficulties	3	3	-1



19	I would talk about sex and intimacy because there may be no-one else who will	2	-1	3
20	I would talk to about sex and intimacy as part of developing a trusting therapeutic relationship	1	-2	-1
21	Talking about sex and intimacy is important as it is a major factor in many people's lives	6	1	0
22	Talking about sex and intimacy is important because it may help someone access much-needed social support	2	1	0
23	Talking about sex and intimacy is important because the social support people can access may help them prevent relapse	2	0	0
24	A discussion about sex and intimacy might be an important part of someone's recovery process	5	5	4
25	Cognitive impairment might negatively affect the ability to engage in a discussion about sex and intimacy	-1	0	-3
26	I would be mindful that a person might be too socially isolated to have intimate relationships	0	1	0
27	I would not talk about sex and intimacy because I would assume that people do not have the social skills to maintain a relationship	-4	-5	-4
28	I would be mindful of how uncomfortable and awkward it might be for someone to talk about sex and intimacy	1	5	5
29	I would be mindful that people might feel too ashamed or embarrassed to talk about sex and intimacy	1	6	5
30	I would be mindful of the emotional pain of talking about sex and intimacy	3	5	2
31	I would be mindful that people might struggle to be honest about how much they know about sex and intimate relationships	0	3	0
32	I like to let people know that it is OK for them to have gaps in their knowledge about sex and intimacy	0	2	1
33	I would be cautious about talking with someone of the opposite gender about sex and intimacy	-1	-1	-1
34	I would be cautious about talking with someone who was older than me about sex and intimacy	-2	-3	-2
35	I like to let people know it is ok to talk about sex and intimacy	4	0	-2
36	I would have to talk about sex and intimacy in order to have a robust and holistic understanding of someone	4	-3	0
37	I would find it hard not to talk about sex and intimacy, as it is often integral to the development of someone's difficulties	2	-2	-2
38	It is important to talk about sex and intimacy as it can be a normalising experience	5	1	1

39	Talking to people about sex and intimate relationships can provide them with the opportunity to talk about other sensitive areas of their lives that impact on their difficulties	4	3	1
40	I do not have training to talk to people about sex	-4	-1	6
41	I would worry that someone's sexual issues would be too complex for me to talk about with them	-3	-2	6
42	I would not feel comfortable talking about sex and intimacy	-3	-2	-2
43	I would not feel competent to talk about sex and intimacy	-5	-3	2
44	Raising issues of sex and intimacy would be embarrassing for me	-2	-2	-1
45	I would worry that I would offend someone if I raised sex and intimacy with them in a session	-2	-3	0
46	I would not talk to people with psychosis about sex and intimacy because I would not expect them to be a good partner	-5	-5	-4
47	I would talk about sex and intimacy because I would feel that it is perfectly normal to speak about it in therapy	4	0	-2
48	I would feel disappointed if someone did not raise issues of sex and intimacy with me if it was important to them	1	0	2
49	Talking about sex and intimacy may not be appropriate if someone is currently unstable	-1	1	-1
50	I would not talk about sex and intimacy as someone may become disinhibited	-3	-3	-3
51	I would not talk to people about sex and intimacy as they may become confused about boundaries	-2	-1	-3
52	I would not talk about sex and intimacy if I felt it may increase someone's distress	-1	2	1
53	I don't think raising issues of sex and intimacy would negatively affect a person's mental health	0	-1	4
54	I would not talk about sex and intimacy as someone may become aroused by it	-4	-1	-4
55	I would not talk about sex and intimacy as people can be unpredictable and scary and they may act on our conversations with non-consenting others	-4	-4	-4
56	I would not talk about sex and intimacy because it might affect someone's behaviour in a ward environment	-1	-4	-3
57	I would worry that talking about sex and intimacy might encourage someone to engage in unsafe sex	-3	-4	-5
58	I would worry that talking about sex and intimacy might result in an unwanted pregnancy occurring	-3	-5	-5
59	I would feel comfortable discussing sex and intimacy because these topics are part of what it means to be human	6	2	-1

60	I would feel comfortable talking about sex and intimacy because peoples' needs in these areas are often overlooked or ignored by clinicians and helpers	2	1	1
61	I would feel comfortable talking about sex and intimacy, as this might be a sign of growing trust and good progress in psychological therapy	2	0	-1
62	I would feel uncomfortable talking about sex and intimacy if I had reason to believe that someone might misinterpret such a discussion as a sign of my own sexual interest in them	-2	4	0
63	I would feel uncomfortable talking about sex and intimacy if the acts of thinking and talking about these subjects might be too distressing for someone to manage	0	3	4
64	I would feel uncomfortable talking about sex and intimacy because it may add to a person's persecutory beliefs	-2	-2	-3
65	I would feel uncomfortable talking about sex and intimacy if it significantly increased the risk of someone subsequently placing themselves in a vulnerable situation	0	3	1
66	I would feel uncomfortable talking about sex and intimacy if it significantly increased the risk of someone subsequently harming themselves or someone else	-1	4	2

---

## Appendix P

Correlation matrix showing correlations between Q-sorts

SORTS	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19
1 PEA026	100	62	61	57	72	72	68	72	56	72	65	58	56	49	65	65	76	63	71
2 EVA071	62	100	64	63	72	71	74	73	58	74	61	44	40	45	61	73	76	71	45
3 BLA210	61	64	100	53	62	64	76	58	41	74	75	41	37	29	64	58	65	73	45
4 EAS	57	63	53	100	69	59	58	64	51	59	43	58	44	47	60	70	61	49	51
5 CAT171	72	72	62	69	100	72	70	84	60	74	61	63	64	61	76	84	81	71	58
6 KAU019	72	71	64	59	72	100	66	70	69	71	62	55	54	58	62	71	74	66	67
7 W00070	68	74	76	58	70	66	100	71	52	74	71	49	47	36	71	60	73	74	51
8 GLA019	72	73	58	64	84	70	71	100	59	73	59	66	57	59	76	80	83	77	54
9 DEA020	56	58	41	51	60	69	52	59	100	47	31	62	60	55	45	69	61	48	65
10 SIM609	72	74	74	59	74	71	74	73	47	100	79	41	34	38	77	64	81	79	47
11 SMI019	65	61	75	43	61	62	71	59	31	79	100	26	22	26	79	49	70	78	37
12 LER060	58	44	41	58	63	55	49	66	62	41	26	100	69	59	49	65	50	47	67
13 WHI026	56	40	37	44	64	54	47	57	60	34	22	69	100	57	45	58	44	45	67
14 WIL029	49	45	29	47	61	58	36	59	55	38	26	59	57	100	34	70	52	40	58
15 LAU178	65	61	64	60	76	62	71	76	45	77	79	49	45	34	100	62	76	76	50
16 DUN011	65	73	58	70	84	71	60	80	69	64	49	65	58	70	62	100	77	61	61
17 PAG115	76	76	65	61	81	74	73	83	61	81	70	50	44	52	76	77	100	76	54
18 PRI018	63	71	73	49	71	66	74	77	48	79	78	47	45	40	76	61	76	100	44
19 KT0175	71	45	45	51	58	67	51	54	65	47	37	67	67	58	50	61	54	44	100
20 DUM010	63	68	63	62	66	68	61	57	57	59	55	54	65	50	59	67	53	57	68
21 AKH305	57	70	65	49	62	73	67	70	64	71	61	44	44	43	67	60	69	72	48
22 YAR103	77	70	77	57	74	67	77	72	48	77	75	57	52	43	71	61	65	78	57
23 BL070	70	75	59	70	81	73	64	81	63	67	53	66	53	68	64	84	79	67	60
24 AFI706	68	78	63	61	79	74	70	74	60	76	68	59	54	52	71	76	79	70	62
25 KIC212	63	62	69	45	62	52	75	65	50	67	65	56	50	26	72	53	65	72	53
26 RED012	52	60	50	61	68	66	53	68	57	55	49	58	51	68	49	70	59	56	58
27 RAN020	72	60	70	56	70	64	69	72	50	68	63	65	57	38	71	63	73	72	63

## Appendix Q

### Submission requirements for *Clinical Psychology and Psychotherapy* journal

#### **MANUSCRIPT SUBMISSION**

*Clinical Psychology & Psychotherapy* operates an online submission and peer review system that allows authors to submit articles online and track their progress via a web interface. Please read the remainder of these instructions to authors and then visit <http://mc.manuscriptcentral.com/cpp> and navigate to the *Clinical Psychology & Psychotherapy* online submission site.

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#### **Pre-submission English-language editing**

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**File types.** Preferred formats for the text and tables of your manuscript are .doc, .docx, .rtf, .ppt, .xls. **LaTeX** files may be submitted provided that an .eps or .pdf file is provided **in addition** to the source files. Figures may be provided in .tiff or .eps format.

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- **Non-LaTeX users.** Upload your manuscript files. At this stage, further source files do not need to be uploaded.
- **LaTeX users.** For reviewing purposes you should upload a single .pdf that you have generated from your source files. You must use the File Designation "Main Document" from the dropdown box.

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- **LaTeX users.** When submitting your revision you must still upload a single .pdf that you have generated from your revised source files. You must use the File Designation "Main Document" from the dropdown box. In addition you must upload your TeX source files. For all your source files you must use the File Designation "Supplemental Material not for review". Previous versions of uploaded documents must be deleted. If your manuscript is accepted for publication we will use the files you upload to typeset your article within a totally digital workflow.

#### **MANUSCRIPT STYLE**

The language of the journal is English. 12-point type in one of the standard fonts: Times, Helvetica, or Courier is preferred. It is not necessary to double-line space your manuscript. Tables must be on separate pages after the reference list, and not be incorporated into the main text. Figures should be uploaded as separate figure files.

- During the submission process you must enter the full title, short title of up to 70 characters and names and affiliations of all authors. Give the full address, including email, telephone and fax, of the author who is to check the proofs.
- Include the name(s) of any **sponsor(s)** of the research contained in the paper, along with **grant number(s)** .

- Enter an **abstract** of up to 250 words for all articles [except book reviews]. An abstract is a concise summary of the whole paper, not just the conclusions, and is understandable without reference to the rest of the paper. It should contain no citation to other published work.
- All articles should include a **Key Practitioner Message** — 3-5 bullet points summarizing the relevance of the article to practice.
- Include up to six **keywords** that describe your paper for indexing purposes.

#### Types of Articles

- **Research Articles:** Substantial articles making a significant theoretical or empirical contribution.
- **Reviews:** Articles providing comprehensive reviews or meta-analyses with an emphasis on clinically relevant studies.
- **Assessments:** Articles reporting useful information and data about new or existing measures.
- **Practitioner Reports:** Shorter articles (a maximum of 1200 words) that typically contain interesting clinical material. These should use (validated) quantitative measures and add substantially to the literature (i.e. be innovative).

**Title and Abstract Optimisation Information.** As more research is read online, the electronic version of articles becomes ever more important. In a move to improve search engine rankings for individual articles and increase readership and future citations to Clinical Psychology & Psychotherapy at the same time please visit **Optimizing Your Abstract for Search Engines** for guidelines on the preparation of keywords and descriptive titles.

**Illustrations.** Upload each figure as a separate file in either .tiff or .eps format, the figure number and the top of the figure indicated. Compound figures e.g. 1a, b, c should be uploaded as one figure. Grey shading and tints are not acceptable. Lettering must be of a reasonable size that would still be clearly legible upon reduction, and consistent within each figure and set of figures. Where a key to symbols is required, please include this in the artwork itself, not in the figure legend. All illustrations must be supplied at the correct resolution:

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1. **A typical citation of an entire work consists of the author's name and the year of publication .**  
Example: Charlotte and Emily Bronte were polar opposites, not only in their personalities but in their sources of inspiration for writing (Taylor, 1990). Use the last name only in both first and subsequent citations, except when there is more than one author with the same last name. In that case, use the last name and the first initial.
2. **If the author is named in the text, only the year is cited .**  
Example: According to Irene Taylor (1990), the personalities of Charlotte. .
3. **If both the name of the author and the date are used in the text, parenthetical reference is not necessary.**  
Example: In a 1989 article, Gould explains Darwin's most successful. . .
4. **Specific citations of pages or chapters follow the year .**  
Example: Emily Bronte "expressed increasing hostility for the world of human relationships, whether sexual or social" (Taylor, 1988, p. 11).
5. **When the reference is to a work by two authors, cite both names each time the reference appears .**  
Example: Sexual-selection theory often has been used to explore patters of various insect matings (Alcock & Thornhill, 1983) . . . Alcock and Thornhill (1983) also demonstrate. . .
6. **When the reference is to a work by three to five authors, cite all the authors the first time the reference appears. In a subsequent reference, use the first author's last name followed by *et al* . (meaning "and others") .**  
Example: Patterns of byzantine intrigue have long plagued the internal politics of community college administration in Texas (Douglas *et al* ., 1997) When the reference is to a work by six or more authors, use only the first author's name followed by *et al* . in the first and all subsequent references. The only

exceptions to this rule are when some confusion might result because of similar names or the same author being cited. In that case, cite enough authors so that the distinction is clear.

7. **When the reference is to a work by a corporate author, use the name of the organization as the author.**

Example: Retired officers retain access to all of the university's educational and recreational facilities (Columbia University, 1987, p. 54).

8. **Personal letters, telephone calls, and other material that cannot be retrieved are not listed in References but are cited in the text .**

Example: Jesse Moore (telephone conversation, April 17, 1989) confirmed that the ideas. . .

9. **Parenthetical references may mention more than one work, particularly when ideas have been summarized after drawing from several sources. Multiple citations should be arranged as follows .**

Examples:

- List two or more works by the same author in order of the date of publication: (Gould, 1987, 1989)
- Differentiate works by the same author and with the same publication date by adding an identifying letter to each date: (Bloom, 1987a, 1987b)
- List works by different authors in alphabetical order by last name, and use semicolons to separate the references: (Gould, 1989; Smith, 1983; Tutwiler, 1989).

## Reference List

### APA – American Psychological Association

References should be prepared according to the Publication Manual of the American Psychological Association (6th edition). This means in text citations should follow the author-date method whereby the author's last name and the year of publication for the source should appear in the text, for example, (Jones, 1998). The complete reference list should appear alphabetically by name at the end of the paper.

A sample of the most common entries in reference lists appears below. Please note that a DOI should be provided for all references where available. For more information about APA referencing style, please refer to the APA FAQ. Please note that for journal articles issue numbers are not included unless each in the volume begins with page one.

#### Journal article

Beers, S. R. , & De Bellis, M. D. (2002). Neuropsychological function in children with maltreatment-related posttraumatic stress disorder. *The American Journal of Psychiatry*, 159, 483–486.  
doi:10.1176/appi.ajp.159.3.483.

#### Book edition

Bradley-Johnson, S. (1994). Psychoeducational assessment of students who are visually impaired or blind: Infancy through high school (2nd ed.). Austin, TX: Pro-ed.

\*The Digital Object Identifier (DOI) is an identification system for intellectual property in the digital environment. Developed by the International DOI Foundation on behalf of the publishing industry, its goals are to provide a framework for managing intellectual content, link customers with publishers, facilitate electronic commerce, and enable automated copyright management.

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## Appendix R

Email from the editor of *Clinical Psychology and Psychotherapy* journal

**From:** Power, Michael John <psypmj@nus.edu.sg>

**Sent:** 17 October 2016 09:18

**To:** Southall Daniel (SOUTH STAFFORDSHIRE AND SHROPSHIRE HEALTHCARE NHS FOUNDATION TRUST); P.M.G.Emmelkamp@uva.nl

**Subject:** RE: Forthcoming articles on sex and intimate relationships in individuals with psychosis

We consider all such articles on their merits by putting them through the normal review process.

Sincerely,

Mick Power  
Clinical Psychology and Psychotherapy

Professor and Director of Clinical Psychology Programmes  
National University of Singapore

Website: [www.nus.edu.sg](http://www.nus.edu.sg)

---

**From:** Southall Daniel (SOUTH STAFFORDSHIRE AND SHROPSHIRE HEALTHCARE NHS FOUNDATION TRUST) [daniel.southall@nhs.net]

**Sent:** 14 October 2016 22:36

**To:** P.M.G.Emmelkamp@uva.nl; Power, Michael John

**Subject:** Forthcoming articles on sex and intimate relationships in individuals with psychosis

Dear Sirs,

I am writing to enquire whether you would be interested in a submission of either of the papers I am preparing as part of my professional doctorate in clinical psychology.

I am in the process of writing a review paper examining the qualitative literature on barriers to accessing sexual and intimate relationships for individuals with psychosis.

My original paper will be a Qmethodology study exploring views and attitudes of clinical psychologists on discussing issues of sex and intimacy with individuals with psychosis.

Papers will be approximately 7 - 8000 words in length. At the moment submission time is June - July 2017.

Best wishes,

Dan Southall

Dan Southall  
Trainee Clinical Psychologist  
[daniel.southall@nhs.net](mailto:daniel.southall@nhs.net)

Appendix S  
Email invitation to clinical psychologists requesting statements

Hi XXXX,

I wondered if you would be interested in undertaking an exercise for my research project?

I am looking at clinical psychologists' views on talking to people with psychosis about sex and intimate relationships. I am using a Qsort methodology for this, which involves a number of statements (40 - 60) that cover broadly all and any possible views that clinical psychologists could have about talking to people with psychosis about sex and intimacy. Participants will be asked to rank the statements from -6 (disagree strongly) to +6 agree strongly.

What I want to do is to ask clinical psychologists to provide me with example statements, perhaps ten statements, that would reflect possible views that they might have or that might occur to them about talking to clients with psychosis about sex and intimacy. So, examples might be:

- I would not feel comfortable talking to clients with psychosis about sex and intimacy
- I would not talk to clients with psychosis about sex and intimacy because I would worry that they might have unprotected sex
- I would not talk to clients with psychosis because side effects from medication cause a lack of libido

etc etc.

The Q-methodology literature is not prescriptive about how statements need to be generated, and in the development stages they can come from a range of sources. I'm asking psychologists from a range of settings to get a broad perspective.

Thanks,

Dan

Appendix T  
Q-set

<b>No.</b>	<b>Statement</b>
1	I would talk about it sex and intimacy if I felt it were relevant and clinically appropriate
2	I would prioritise other issues in therapy that might not include sex and intimacy
3	I would consider discussing issues of sex and intimacy just as appropriate with clients with psychosis as I would with clients with any presentation
4	Any thorough assessment should cover intimate relationships
5	Asking about sex and intimacy may be necessary as part of a risk assessment
6	I would ask questions about sex and intimacy if I suspected a person was vulnerable to abuse
7	I would ask questions about sex and intimacy if I was aware that someone had experienced previous abuse or sexual trauma
8	I would talk about sex and intimacy if someone was already in an intimate relationship
9	I would not talk to people experiencing psychosis about sex and intimate relationships as they don't have any experiences of these things
10	It is not important for people with psychosis to have sexual relationships
11	People with psychosis will never have sex
12	It would be unkind to talk to people about things that are never going to happen for them
13	People with psychosis are not interested in developing intimate or sexual relationships
14	Sexual difficulties caused by anti-psychotic medication might affect the ability to have sexual relationships
15	People should be able to talk to professionals about sex and intimacy
16	It is important to respect that some people do not want to talk about sex and intimacy
17	It is important not to make assumptions about a person's experiences and attitudes towards sex
18	Asking about sex and intimacy can help some people feel more open to talking about their difficulties
19	I would talk about sex and intimacy because there may be no-one else who will

- 20 I would talk to about sex and intimacy as part of developing a trusting therapeutic relationship
- 21 Talking about sex and intimacy is important as it is a major factor in many people's lives
- 22 Talking about sex and intimacy is important because it may help someone access much-needed social support
- 23 Talking about sex and intimacy is important because the social support people can access may help them prevent relapse
- 24 A discussion about sex and intimacy might be an important part of someone's recovery process
- 25 Cognitive impairment might negatively affect the ability to engage in a discussion about sex and intimacy
- 26 I would be mindful that a person might be too socially isolated to have intimate relationships
- 27 I would not talk about sex and intimacy because I would assume that people do not have the social skills to maintain a relationship
- 28 I would be mindful of how uncomfortable and awkward it might be for someone to talk about sex and intimacy
- 29 I would be mindful that people might feel too ashamed or embarrassed to talk about sex and intimacy
- 30 I would be mindful of the emotional pain of talking about sex and intimacy
- 31 I would be mindful that people might struggle to be honest about how much they know about sex and intimate relationships
- 32 I like to let people know that it is OK for them to have gaps in their knowledge about sex and intimacy
- 33 I would be cautious about talking with someone of the opposite gender about sex and intimacy
- 34 I would be cautious about talking with someone who was older than me about sex and intimacy
- 35 I like to let people know it is ok to talk about sex and intimacy
- 36 I would have to talk about sex and intimacy in order to have a robust and holistic understanding of someone
- 37 I would find it hard not to talk about sex and intimacy, as it is often integral to the development of someone's difficulties
- 38 It is important to talk about sex and intimacy as it can be a normalising experience
- 39 Talking to people about sex and intimate relationships can provide them with the opportunity to talk about other sensitive areas of their lives that impact on their difficulties
- 40 I do not have training to talk to people about sex
- 41 I would worry that someone's sexual issues would be too complex for me to talk about with them

- 42 I would not feel comfortable talking about sex and intimacy
- 43 I would not feel competent to talk about sex and intimacy
- 44 Raising issues of sex and intimacy would be embarrassing for me
- 45 I would worry that I would offend someone if I raised sex and intimacy with them in a session
- 46 I would not talk to people with psychosis about sex and intimacy because I would not expect them to be a good partner
- 47 I would talk about sex and intimacy because I would feel that it is perfectly normal to speak about it in therapy
- 48 I would feel disappointed if someone did not raise issues of sex and intimacy with me if it was important to them
- 49 Talking about sex and intimacy may not be appropriate if someone is currently unstable
- 50 I would not talk about sex and intimacy as someone may become disinhibited
- 51 I would not talk to people about sex and intimacy as they may become confused about boundaries
- 52 I would not talk about sex and intimacy if I felt it may increase someone's distress
- 53 I don't think raising issues of sex and intimacy would negatively affect a person's mental health
- 54 I would not talk about sex and intimacy as someone may become aroused by it
- 55 I would not talk about sex and intimacy as people can be unpredictable and scary and they may act on our conversations with non-consenting others
- 56 I would not talk about sex and intimacy because it might affect someone's behaviour in a ward environment
- 57 I would worry that talking about sex and intimacy might encourage someone to engage in unsafe sex
- 58 I would worry that talking about sex and intimacy might result in an unwanted pregnancy occurring
- 59 I would feel comfortable discussing sex and intimacy because these topics are part of what it means to be human
- 60 I would feel comfortable talking about sex and intimacy because peoples' needs in these areas are often overlooked or ignored by clinicians and helpers
- 61 I would feel comfortable talking about sex and intimacy, as this might be a sign of growing trust and good progress in psychological therapy
- 62 I would feel uncomfortable talking about sex and intimacy if I had reason to believe that someone might misinterpret such a discussion as a sign of my own sexual interest in them

- 63 I would feel uncomfortable talking about sex and intimacy if the acts of thinking and talking about these subjects might be too distressing for someone to manage
- 64 I would feel uncomfortable talking about sex and intimacy because it may add to a person's persecutory beliefs
- 65 I would feel uncomfortable talking about sex and intimacy if it significantly increased the risk of someone subsequently placing themselves in a vulnerable situation
- 66 I would feel uncomfortable talking about sex and intimacy if it significantly increased the risk of someone subsequently harming themselves or someone else
-

## **Chapter 3: Commentary and Reflective Review**

### **A Recovery-Orientated Account of My Thesis Journey**

**Word count: 2, 716**

## **Abstract**

Clinical psychologists are often presented with challenging experiences in their work, but as a profession are encouraged to adopt the position of reflective practitioners to enable the transformation of challenges into learning experiences, (Division of Clinical Psychology, 1995; British Psychological Society, 2008). This reflective review describes the experience of developing, researching and writing the thesis from initial idea through to the final writing of the papers. The review is arranged in chapters based on recovery principles and is written in the first person to highlight personal learning, personal and professional reflections and challenges raised by the research process.



## Introduction

Reflective practice is encouraged within clinical psychology because it allows clinicians to accommodate personal and professional experience within practice, creating new opportunities for learning and development alongside the application of scientific knowledge (British Psychological Society, 2010). A reflective practitioner can reflect on situations within the moment as well as retrospectively (Schön, 1983; 1987). The ability to reflect on experiences allows the clinician to become more dynamic and responsive in their practice (Johns, 2004). From the process of adapting to situations – both positive and challenging – and taking learning from these situations onto further professional situations, reflective practice enables the formation of new insights into self and practice.

Recovery from psychosis is based on a set of 9 principles (see Figure 3.1), each of which is important to the individual, but which must be self-directed to encourage them to take control of their own life (Davidson et al., 2007). This reflective account is presented in short chapters to emphasise lessons that I feel were the most valuable, some of which are matched with a recovery principle that I associate with that step. Each lesson is coupled with a photograph depicting events from that time. The distressing experience of psychosis is by no means comparable to that of completing a doctoral thesis; however, some of the recovery principles reflect the learning and personal development I have acquired as I have progressed through the thesis process (Drake & Whitley, 2014).

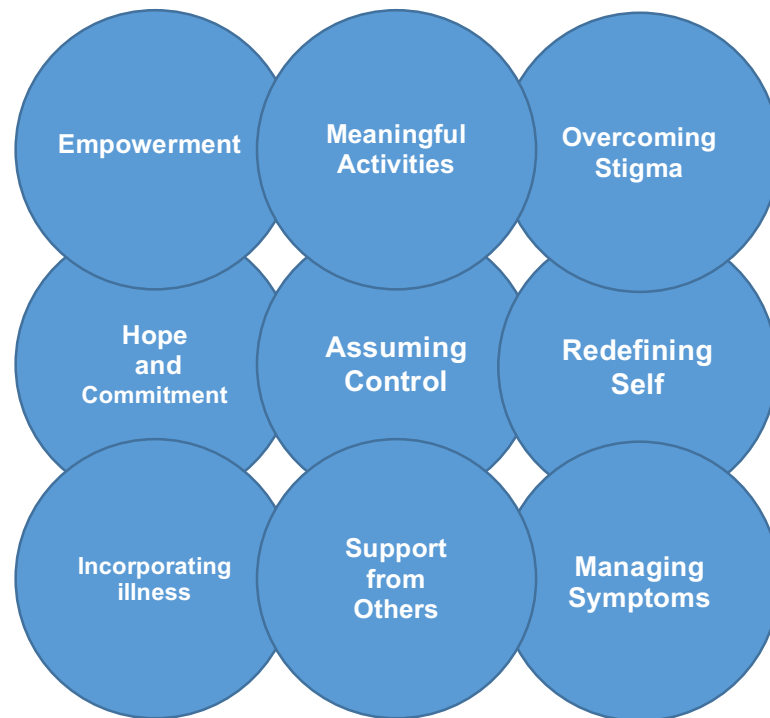


Figure 3.1. Recovery principles.

### **1. Engaging in Meaningful Activities: Finding a Research Question**

Deciding on a research topic was not difficult, as I hoped to continue with an area of interest as well as produce work that would be clinically beneficial. Psychosocial factors involved in the cause and maintenance of psychosis, as well as how social networks can benefit in the recovery process, have remained my main interest in the psychological arena, both in terms of clinical work and research. The reason for choosing a topic related to sexual romantic relationships is a combination of both personal interest and scientific curiosity. The nature of psychotic experiences is fascinating, particularly the mechanisms underlying auditory hallucinations, but this type of research tends to take a largely cognitive perspective which was less attractive. The decision to explore the role of sexual and intimate relationships in psychosis came about my own personal reflections, thinking about how my own supportive relationships have enabled me to grow, particularly whilst I have been studying.



Image 1. Blur Live in Hyde Park, 20<sup>th</sup> June 2015.

The importance of deciding on a research topic that would contribute to scientific knowledge was paramount. Being somewhat sceptical of current cognitive-behavioural approaches within British clinical psychology, the recovery movement from the perspective of Rufus May (May, 2004) and Mike Slade (Slade & Adams, 2012) had more of an attraction. Recovery encompasses nine principles that encourage people with mental health difficulties to take control of their lives and change their own psychological and social world, including developing a sense of hope and agency, overcoming stigma, creating meaning and purpose in life and finding comfort in social networks and close relationships. Chris Quinn and Eddie McCann's work explored the role of nursing in addressing sexual relationships with people with psychosis (Gascoyne, McCann, Hughes, & Quinn, 2016; Quinn Happell, & Browne, 2011), but there was a paucity in literature exploring the role of clinical psychology in talking about sex. This was an exciting realisation, and the first step in the research journey! Not only was this a niche area that warranted further exploration, but the research could also contribute to a burgeoning area of interest that had potential clinical benefits for people with psychosis.

This part of the thesis process represented the importance of meaningful activities, as active engagement in work you are invested in can lead to goal achievement and success (Leamy, Bird, Le Boutillier, Williams, & Slade, 2011). Important strands of learning from this stage were the most positive, stress-free lessons in the whole of the process of conducting the research and writing the papers: you have a head start if you are interested in your topic and you have a good idea of what you want to contribute to the scientific arena.

## **2. Being Supported by Others and Managing ‘Symptoms’ (Challenges): Navigating the Ethics World**

I was ill-prepared for the level of work involved with preparing the research proposal for the ethics process and then working through several channels to seek approval. The main problem was not realising just how complicated the process is when you are conducting research with people outside of the university setting – i.e. not students. Conducting research with students is relatively straightforward, but with people who could *potentially* vulnerable it is much more complex.

Where to start on the ethics journey? There were acronyms everywhere – IRAS, R&D, HRA, REC approval. Fortunately, we had very high quality teaching about ethics and the process of seeking ethical approval – including some provided by the NHS Research and Development team. It was still a very difficult process because there are different forms and processes for everyone depending on the population you are examining and the settings you intend to recruit from. Most of the questions on the forms were not relevant to the research I was planning, such as using or transporting human tissue or using invasive procedures; some were more challenging and required forethought. Was I planning to deceive people? Would my participants be at risk of distress? Although my research was not asking about the sexual and intimate relationship experiences of participants, it was important to assess the possibility of challenging situations and reduce the likelihood of distress (Division of Clinical Psychology, 1995; British Psychological Society, 2010).



Image 2. Redecorating with Simon, 28<sup>th</sup> April 2016.

The strain becomes greater the more you wait for answers and face uncertainty. I felt inclined to not do any more work at this stage, which was impacted upon by the myriad personal difficulties I was managing in and out of clinical training. Taking a break from clinical psychology, spending time with friends and doing something different helped me get back on track. In addition, thanks to a great deal of support from the teaching team, I progressed through the ethics process successfully. The importance of supportive networks in overcoming challenges cannot be underestimated (Soundy et al., 2015). The learning lesson here was in responding to lonely periods by setting goals and managing your time effectively, and asking for help especially when you need it and have been offered it.

### **3. Assuming Control: Building Up the Literature Review**

A fundamental part of the recovery journey is a sense of empowerment and assuming control of one's life (Leamy, Bird, Le Boutillier, Williams, & Slade, 2011).

Both adjusting to a new personal life and the sheer scale of the literature review often caused me to doubt my academic ability and my own sense of agency in managing the work. Personal challenges were overcome with a considerable amount of psychological effort.

I felt it was essential to produce a literature review that was conducted systematically in a stepwise process and did not repeat previous reviews on sexuality and intimacy. Deciding on a topic was straightforward, as I quickly identified a gap in the published reviews. The difficult process was maintaining momentum throughout, facilitated by continuously reminding myself that I had the skills, time and resources to succeed (Bandura, 1977; Zimmerman, 2000).

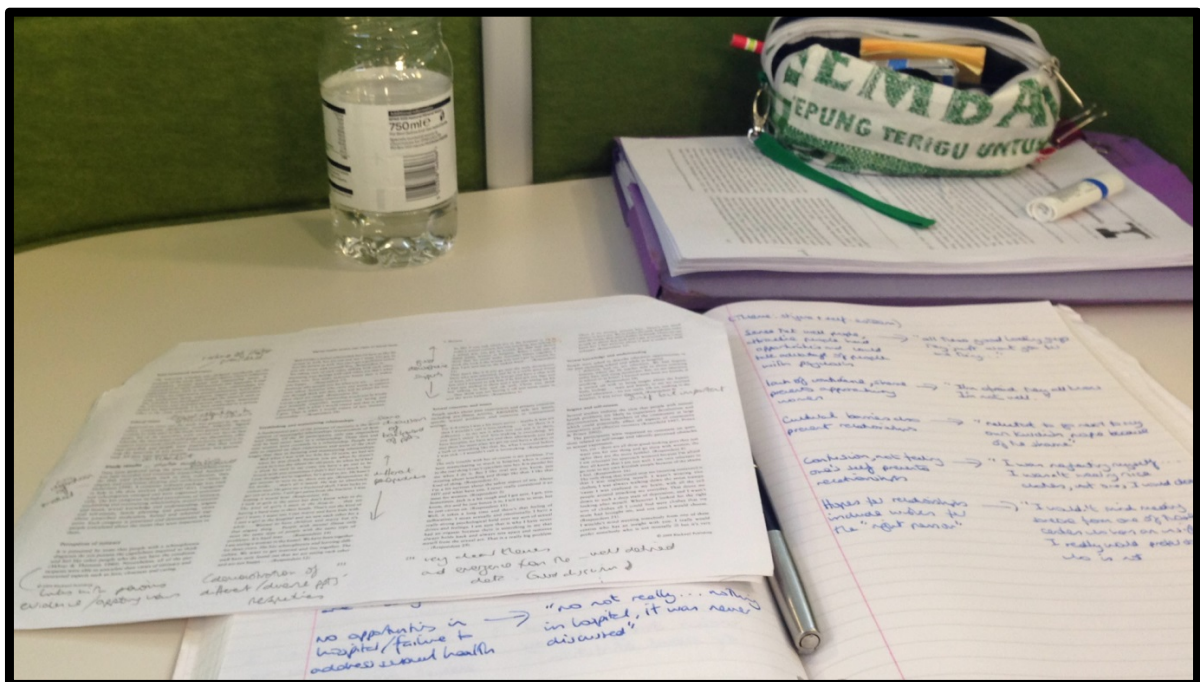


Image 3. Synthesising research papers, Lancaster University library, 9<sup>th</sup> November 2016.

The important practical steps that enabled me to work through the literature review were an accessible textbook (e.g. Booth, Papaioannou, & Sutton, 2012) and the comparison of many literature reviews to use as yardsticks – some excellent in quality, some lesser so.

This part of the thesis was exceptionally difficult. Using thematic synthesis to collate all the findings in the studies (Thomas & Harden, 2008) was a vast task and took many weeks. Developing a critical appraisal system based on an existing tool (Spencer, Ritchie, Lewis, & Dillon, 2003) caused many issues and meant that I had to revise my approach in order to develop a coherent critical narrative.

The learning lesson at this point: if you believe that you can succeed, and you take each part of the journey one step at a time, you will eventually reach the end.

#### **4. Redefining Self: The Experience of Using Q-methodology**

The prospect of conducting research using a new methodology was daunting but appealing. Q-methodology draws on both quantitative and qualitative approaches, meaning that researchers can enjoy the richness of qualitative data as well as drawing on traditional factor analysis (van Exel & de Graaf, 2005). Having previously identified myself as a quantitative researcher with a reasonable experience of statistical packages, I needed to redefine my research skills and adjust to a new identity as a quasi-qualitative researcher!

Q-methodology is not overly complex, but the individual steps in the research process do take time to navigate (Watts & Stenner, 2012). Q-sort requires the development of a set of statements that participants rank in terms of their subjective views (van Exel & de Graaf, 2005). The development of the Q-sort statements took some considerable time to develop, and even an extensive search of the literature

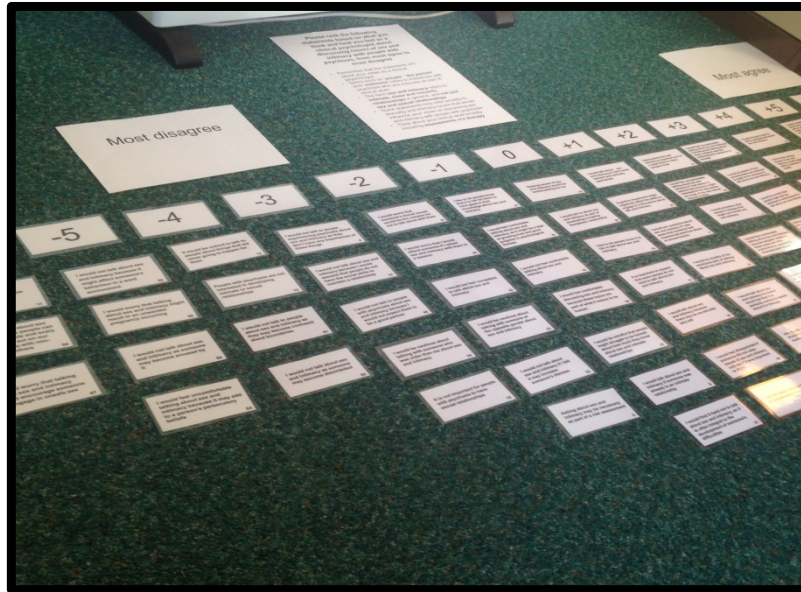


Image 4: Conducting the Q-sort, Stafford, 25<sup>th</sup> November 2016.

and the submission of statements by many experienced colleagues did not provide an exhaustive Q-set. Subsequently, I was never fully satisfied with the materials I developed. Ultimately, the experience of using Q-methodology was positive, and I am pleased with having worked through the analysis process and made sense of the data I collected as a researcher with a new set of skills. This part of the thesis process reflected what many individuals recovering from mental health issues experience, a combination of self-efficacy and redefined identity (Tew et al, 2012).

### **5. Incorporating 'illness': Acknowledging Mistakes and Accepting Limitations**

This stage in the recovery journey is typically the first step that individuals overcoming serious mental health issues progress through (Davidson et al., 2007), but in my case it was a step that came close to the end. As I made the final changes to the study and prepared the empirical paper I started to reflect on some of the mistakes I had made in both the literature review and the empirical paper. At times, I found myself looking for more and more mistakes, allowing the critical thoughts to multiply and rotate.



The literature review had been caused a significant amount of anxiety because I had no previous experience of such a task. This resulted in novice mistakes and a few weeks' delay. I started to think about the Q-sort, and how unsystematically the statements had been developed. I had neglected to collect information about participants' ethnicity in the demographics, something which a couple of participants had commented on. By the time I realised I had made these mistakes it was too late to rectify them. I also realised that I was ruminating, and that focusing on failures was not going to be beneficial in the long term (Nolen-Hoeksema, Wisco, & Lyubomirsky, 2008). All research is flawed and no study is perfect. All good researchers make mistakes with their studies; the key is to congratulate yourself for achieving what you have, learn from your mistakes and move on to the next project.



Image 5. Stoke-on-Trent station, 26th February 2017.

## **6. Overcoming Stigma: Disseminating the Findings**

Clinical psychologists in training are encouraged to embrace the scientist-practitioner model, drawing on psychological research and knowledge in their roles as clinicians whilst contributing to the scientific progression of the profession (British Psychological Society, 2010; Shapiro, 2002). The role of an applied psychologist is

one I take seriously, and one that I enjoy. Collecting and analysing data is an exciting process when it is your own work. Preparing a manuscript for submission means potentially producing work that other academics will take note of and clinicians might use to inform their clinical work.

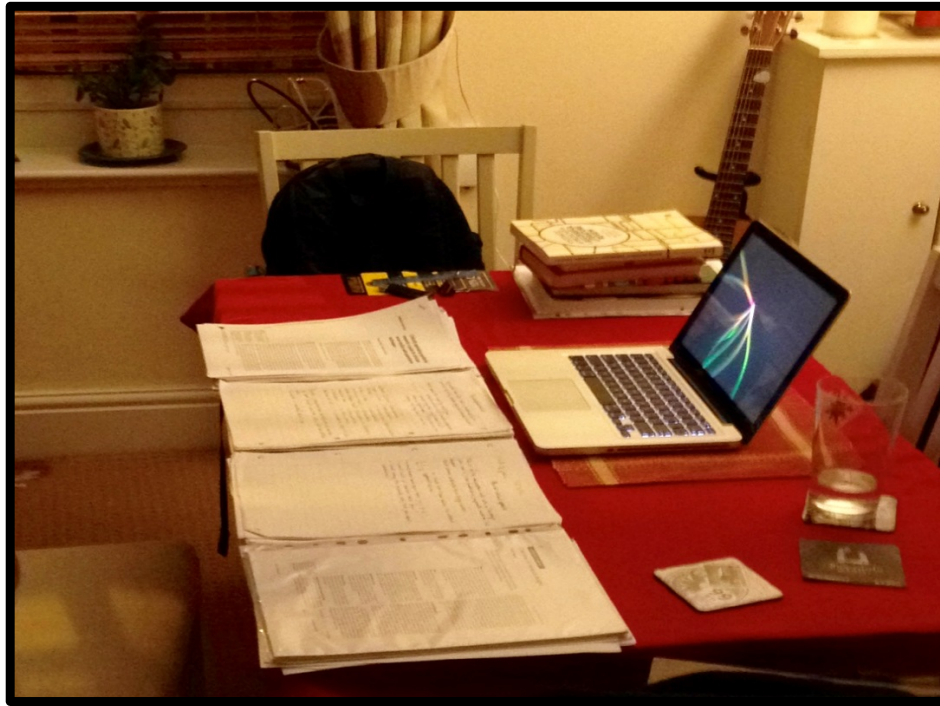


Image 6. The workstation. Stone, Staffordshire, 17<sup>th</sup> March 2017.

I don't know if this work will ever be published in an academic journal, but the personal importance of it is in unearthing knowledge that didn't exist before. In my literature review, I discovered that people prescribed anti-psychotic medication suffer from secondary psychological distress such as impaired sense of self and identity caused by unpleasant physical side-effects. My empirical paper revealed that, whilst some clinical psychologists are comfortable talking to their clients about sexuality and intimate relationships, many others feel they need further professional training and guidance to do so comfortably and appropriately.

I hope to spend a long and enjoyable career working with people with psychosis; it is the reason I initially pursued a career in clinical psychology and an area that

continues to fascinate me scientifically. I am passionate about my work, and have witnessed the social exclusion and marginalisation that people with psychosis experience. To contribute to the scientific literature in a way that might benefit people with psychosis is a very positive prospect.

## 7. Renewing Hope and Commitment: Close to the End

The writing process leading up to submission also represented a significant part of my own personal development. I estimate that I have spent at least 600 hours working on the thesis, including preparing and writing the literature review, critically appraising and synthesising papers, creating the Q concourse, writing introductions for both papers, collecting and analysing data, interpreting the outcomes and writing up the final stages. With so much time spent working in isolation, it was very easy to start to lose hope in the last few weeks.



Image 7. Outdoor gear ready for post-thesis adventures, 4<sup>th</sup> March 2017.

I was reminded of my Masters dissertation, and the theory of hope that I was exploring as part of my research. The positive psychology conceptualisation of hope is having goals and concurrently being psychologically aware of the effort needed – *agency thinking* – and the resources – *pathways thinking* – to achieve the goals (Snyder, 2002). I drew on advice from Robert Wicks, a proponent of resilience in helping professions who recommends that clinicians create comprehensive self-care programmes to support themselves to avoid stress (Wicks, 2008). This part of the recovery journey requires individuals to be goal- and future- oriented, with an emphasis on a positive sense of self. The most important parts for me in the last few weeks were planning time with friends after submission and working through tasks one day at a time. The final few weeks were characterised by long days working, but with the constant reminders of the goals I was working towards. I kept electronic ‘*Stickies*’ on my laptop to remind me of each task, and I ticked each one off as I completed them. I gave myself a reward such as a film, a run or a takeaway, when I met a goal. The learning lesson: challenges can be overcome if you plan how you intend to manage them and you believe that you will succeed.

### **8. Summary: A New Sense of Self**

An iterative process of the developing self, personal growth and the emergence of a new identity is often highlighted as the core of recovery (Connell, Schweitzer, & King, 2015; Soundy et al., 2015). The process of creating a burdensome but meaningful piece of work has encouraged me to think about the many personal, professional and academic lessons I have learned along the way: the importance of meaningful work, the restorative nature of positive support networks, and the link between hopeful goal-setting and achievement. I will take these lessons with me and continue to reflect on them as I move on to new professional challenges.

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